

Boston University


SCHOOL OF
SOCIAL WORK



LIBRARY

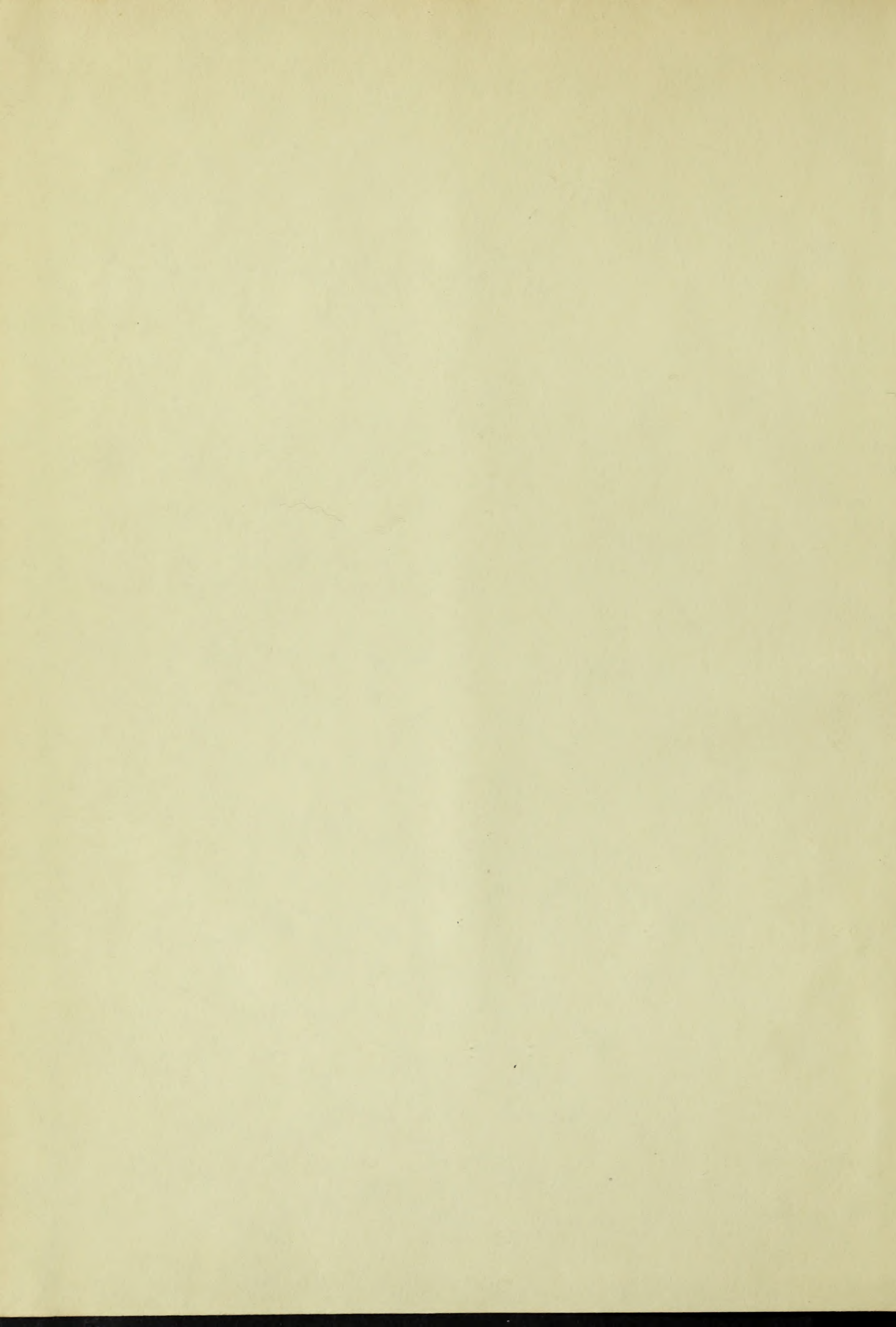
Gift of

Author



Digitized by the Internet Archive
in 2014

<https://archive.org/details/studyoffosterhom00rank>



Thesis
Rankin, M.E.
1954

7210-5

TABLE OF CONTENTS

CHAPTER	PAGE
I. INTRODUCTION	1
BOSTON UNIVERSITY SCHOOL OF SOCIAL WORK	
II. MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH	3
A STUDY OF THE FOSTER HOME ADJUSTMENT OF ELEVEN CHILDREN REFERRED BY CRIPPLED CHILDREN'S SERVICES OF THE MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH TO CHILDREN'S MISSION TO CHILDREN	
III.	10
IV. IMPORTANT FACTORS IN THE PLACEMENT OF HANDICAPPED CHILDREN	17
V. FOUR CASES OF CHILDREN WHOSE ADJUSTMENT TO PLACEMENT WERE SUCCESSFUL	28
VI. FOUR CASES OF CHILDREN WHOSE ADJUSTMENT TO PLACEMENT WERE UNSUCCESSFUL	40
Submitted by	
Mary Elizabeth Rankin	
(B.A. Radcliffe College 1949)	
VII.	51
VIII. SUMMARY AND CONCLUSIONS	62
APPENDIX	In Partial Fulfillment of Requirements for
I.	the Degree of Master of Science in Social Service
II. Bibliography	1954

TABLE OF CONTENTS

CHAPTER	PAGE
I. INTRODUCTION	1
<div style="margin-left: 40px;"> Purpose of the Study Scope of the Study Sources of Data Limitations Method of Procedure </div>	
II. MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH	3
<div style="margin-left: 40px;"> Social Work Section Services for Crippled Children </div>	
III. HISTORY AND PHILOSOPHY OF CHILDREN'S MISSION TO CHILDREN	10
IV. IMPORTANT FACTORS IN THE PLACEMENT OF HANDICAPPED CHILDREN	17
V. FOUR CASES OF CHILDREN WHOSE ADJUSTMENTS TO PLACEMENT WERE SUCCESSFUL	28
VI. FOUR CASES OF CHILDREN WHOSE ADJUSTMENT TO PLACEMENT WAS MODERATELY SUCCESSFUL	40
VII. THREE CASES OF CHILDREN WHOSE ADJUSTMENT TO PLACEMENT WAS UNSUCCESSFUL	51
VIII. SUMMARY AND CONCLUSIONS	62
APPENDIX	
I. Schedule	
II. Bibliography	

TABLE OF CONTENTS

CHAPTER		PAGE
I.	INTRODUCTION	1
	Purpose of the Study	
	Scope of the Study	
	Sources of Data	
	Limitations	
	Method of Procedure	
II.	MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH	3
	Social Work Section	
	Services for Crippled Children	
III.	HISTORY AND PHILOSOPHY OF CHILDREN'S	10
	MISSION TO CHILDREN	
IV.	IMPORTANT FACTORS IN THE PLACEMENT OF	17
	HANDICAPPED CHILDREN	
V.	FOUR CASES OF CHILDREN WHOSE ADJUSTMENTS	28
	TO PLACEMENT WERE SUCCESSFUL	
VI.	FOUR CASES OF CHILDREN WHOSE ADJUSTMENT	40
	TO PLACEMENT WAS MODERATELY SUCCESSFUL	
VII.	THREE CASES OF CHILDREN WHOSE ADJUSTMENT	51
	TO PLACEMENT WAS UNSUCCESSFUL	
VIII.	SUMMARY AND CONCLUSIONS	62
APPENDIX		
I.	Schedule	
II.	Bibliography	

CHAPTER I

INTRODUCTION

PURPOSE OF THE STUDY

The primary purpose of this study is to evaluate the adjustment in medical foster homes of eleven physically handicapped children referred for placement by Crippled Children's Services of the Massachusetts Department of Public Health to Children's Mission to Children. For this study, the writer hopes to determine whether the degree of pre-placement planning and preparation in each case contributed to the success or failure of the child's adjustment in the foster home.

SCOPE OF THE STUDY

The study includes all but two children under the care of Crippled Children's Services of the Massachusetts Department of Public Health who were placed in medical foster homes by Children's Mission to Children, between July, 1947 and July, 1953. Although there were additional children referred by Crippled Children's Services to Children's Mission for placement during this period of time, only those children that were accepted and placed were chosen for this study. The two children that were placed but were not included in the study were eliminated because information needed for the purpose of this study was not available in the records.

SOURCES OF DATA

The writer chose for study these eleven children who were referred by Crippled Children's Services to Children's Mission for placement primarily because she was doing field work with Crippled Children's Services and was interested in the use of foster home placement as part of the medical care program of Services for Crippled Children.

Material for this study was extracted from the eleven case records obtained in the open and closed files of both the Massachusetts Department of Public Health, Crippled Children's Services and Children's Mission to Children. The material was secured by use of a schedule which appears in the appendix. Only those parts of the Services for Crippled Children records that pertained to the reason for referral and the pre-placement planning and preparation by the public health social worker were used. For the purpose of this study, the complete Children's Mission record was read. Judgments were made solely on the evidence obtained from the case records.

LIMITATIONS

The writer is limited by the small number of cases under study, and also by the limited amount of material in many of the records, due to individual differences in focus and extent of recording within the same agency, and to differences in recording methods between the two agencies.

SOURCES OF DATA

The writer chose for study these eleven children who were referred by Crippled Children's Services to Children's Mission for placement primarily because she was doing field work with Crippled Children's Services and was interested in the use of foster home placement as part of the medical care program of Services for Crippled Children.

Material for this study was extracted from the eleven case records obtained in the open and closed files of both the Massachusetts Department of Public Health, Crippled Children's Services and Children's Mission to Children.

The material was secured by use of a schedule which appears in the appendix. Only those parts of the Services for Crippled Children records that pertained to the reason for referral and the pre-placement planning and preparation by the public health social worker were used. For the purpose of this study, the complete Children's Mission record was read. Judgments were made solely on the evidence obtained from the case records.

LIMITATIONS

The writer is limited by the small number of cases under study, and also by the limited amount of material in many of the records, due to individual differences in focus and extent of recording within the same agency, and to differences in recording methods between the two agencies.

Some of the records focused mainly on mechanical procedures in the referral and placement processes; others dealt largely with emotional factors. Unit records are used by Services for Crippled Children, which means that all members of the public health team contribute to the same record, allowing, necessarily, only for summarized casework recording.

METHOD OF PROCEDURE

In planning this study, criteria for determining the child's adjustment in the foster home were defined. Successful adjustment is defined as one in which there was over-all progress made in terms of the original reason for placement and in which the child exhibited no severe psychoneurotic symptoms or behavior disturbances beyond the first few weeks of placement. Moderately successful adjustment is defined as one in which there was over-all progress in terms of the original reason for placement, but in which there were some psychoneurotic symptoms or behavior disturbances exhibited throughout placement. An unsuccessful adjustment is one in which the child was unable to tolerate placement; one in which the parent was unable to tolerate placement and asked for removal of the child; or one in which the problems of the child were so severe that the agency had to remove the child from placement. Psychoneurotic symptoms include psychosomatic disturbances; habit disorders such as enuresis, masturbation, etc.; tics; stuttering; extreme anxiety or

Some of the records focused mainly on mechanical procedures in the referral and placement processes; others dealt largely with emotional factors. Unit records are used by services for Crippled Children, which means that all members of the public health team contribute to the same record, allowing, necessarily, only for summarized casework recording.

METHOD OF PROCEDURE

In planning this study, criteria for determining the child's adjustment in the foster home were defined. Successful adjustment is defined as one in which there was overall progress made in terms of the original reason for placement and in which the child exhibited no severe psychoneurotic symptoms or behavior disturbances beyond the first few weeks of placement. Moderately successful adjustment is defined as one in which there was over-all progress in terms of the original reason for placement, but in which there were some psychoneurotic symptoms or behavior disturbances exhibited throughout placement. An unsuccessful adjustment is one in which the child was unable to tolerate placement; one in which the parent was unable to tolerate placement and asked for removal of the child; or one in which the problems of the child were so severe that the agency had to remove the child from placement. Psychoneurotic symptoms include psychosomatic disturbances; habit disorders such as enuresis, masturbation, etc.; tics; stuttering; extreme anxiety or

fearfulness; and feeding difficulties. Symptoms of behavior disturbance include such anti-social behavior as lying; stealing; truanting; disobedience; running away; or chronic aggressive or destructive behavior. *Mission to Children.*

Chapt The eleven cases are to be abstracted according to the schedule appearing in the appendix. Areas to be considered in determining whether pre-placement planning and preparation were adequate are: reason for the referral; the role of the referring worker in arriving at a decision for referral, interpreting the reason to the family and preparing them for the child-placing agency; the role of the referring worker in presenting medical and social data that would be of help to the child-placing agency in selecting a foster home and working with the family; the role of the child-placing worker in preparing the family and child for separation and placement; the selection and preparation of the foster home for the child; and the adjustment of the child during placement. The cases will be placed in the three classifications of successful, moderately successful and unsuccessful adjustment according to the child's overall adjustment in the foster home. In the individual case discussions some attempt will be made to evaluate whether there was any possible relationship between the adequacy of pre-placement planning and preparation and the degree of adjustment to the foster home.

fearfulness; and feeding difficulties. Symptoms of behavior disturbance include such anti-social behavior as lying; stealing; truanting; disobedience; running away; or chronic aggressive or destructive behavior.

The eleven cases are to be abstracted according to the schedule appearing in the appendix. Areas to be considered in determining whether pre-placement planning and preparation were adequate are: reason for the referral; the role of the referring worker in arriving at a decision for referral; interpreting the reason to the family and preparing them for the child-placing agency; the role of the referring worker in presenting medical and social data that would be of help to the child-placing agency in selecting a foster home and working with the family; the role of the child-placing worker in preparing the family and child for separation and placement; the selection and preparation of the foster home for the child; and the adjustment of the child during placement. The cases will be placed in the three classifications of successful, moderately successful and unsuccessful adjustment according to the child's overall adjustment in the foster home. In the individual case discussions some attempt will be made to evaluate whether there was any possible relationship between the adequacy of pre-placement planning and preparation and the degree of adjustment to the foster home.

Chapter II and Chapter III will explain the history, philosophy and function of the Social Work Section and Crippled Children's Services of the Massachusetts Department of Public Health and Children's Mission to Children. Chapter IV will include background material on current thinking and practices in the placement of children in foster homes, the special meaning that placement of handicapped children can assume and current practices in making referrals from a medical setting to social agencies. Chapters V, VI and VII are devoted to case presentations and Chapter VIII to summary and conclusions.

Chapter II and Chapter III will explain the history,

philosophy and function of the Social Work Section and
Crippled Children's Services of the Massachusetts Depart-
ment of Public Health and Children's Mission to Children.

Chapter IV will include background material on current
thinking and practices in the placement of children in fos-
ter homes, the special meaning that placement of handicapped
children can assume and current practices in making referrals
from a medical setting to social agencies. Chapters V, VI
and VII are devoted to case presentations and Chapter VIII
to summary and conclusions.

CHAPTER II

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH SOCIAL WORK SECTION
AND SERVICES FOR CRIPPLED CHILDREN

The evolution of social work in the Massachusetts Department of Public Health has extended over a period of thirty-five years. It has reflected from its beginning the changing philosophy of public health in general and the Massachusetts Department of Public Health in particular.

In the past, public health agencies focused attention on protecting the community from detrimental physical influences such as poor sanitation and the ravages of communicable disease. The latter activity was undertaken to protect the general health of the community from sources of disease that, due to the number of persons made ill, would have widespread effect on public health. Attention was also focused on communicable diseases because of their high mortality rate. In the main, the diseases that affected the public so drastically were venereal disease and tuberculosis. Cancer, though not communicable, was another disease that had high morbidity and mortality rates. The area of communicable disease is still of concern to public health agencies today, but with advances in medicine the morbidity and mortality rates of these diseases have been reduced. Today, public health philosophy has expanded to include the concepts of preventing disease and promoting

CHAPTER II

MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH SOCIAL WORK SECTION AND SERVICES FOR CRIPPLED CHILDREN

The evolution of social work in the Massachusetts Department of Public Health has extended over a period of thirty-five years. It has reflected from its beginning the changing philosophy of public health in general and the Massachusetts Department of Public Health in particular. In the past, public health agencies focused attention on protecting the community from detrimental physical influences such as poor sanitation and the ravages of communicable disease. The latter activity was undertaken to protect the general health of the community from sources of disease that, due to the number of persons made ill, would have widespread effect on public health. Attention was also focused on communicable diseases because of their high mortality rate. In the main, the diseases that affected the public so drastically were venereal disease and tuberculosis. Cancer, though not communicable, was another disease that had high morbidity and mortality rates. The area of communicable disease is still of concern to public health agencies today, but with advances in medicine the morbidity and mortality rates of these diseases have been reduced. Today, public health philosophy has expanded to include the concepts of preventing disease and promoting

health. With ever-widening acceptance of the recognition of the worth of each individual, the concept of promoting health must include such related factors as mental health and social well-being, so that at the present time social work is a vital part of public health services.¹

In the Massachusetts Department of Public Health, social workers were first included in those Divisions of the Department specializing in the treatment of venereal disease, tuberculosis and cancer. As the Department developed to provide more generalized services through the District Health Office plan, social workers were assigned to the eight Districts and then offered social services on a geographical basis.

In 1919, the first medical social worker in the Department of Public Health was appointed as a "Special Investigator" in the sub-division of Venereal Disease. Her duties were mainly concentrated on follow-up, epidemiological investigations and assistance in the educational programs through talks to social and lay groups. As emphasis on epidemiology, follow-up and education increased, the responsibility for these services seemed to belong to other professional groups, more specifically nursing and medical. Social Workers have

¹ Richard R. Vehslage, Medical Social Work in A Public Health Setting, Ch. 2.

health. With ever-widening acceptance of the recognition of the worth of each individual, the concept of promoting health must include such related factors as mental health and social well-being, so that at the present time social work is a vital part of public health services.¹

In the Massachusetts Department of Public Health, social workers were first included in those Divisions of the Department specializing in the treatment of venereal disease, tuberculosis and cancer. As the Department developed to provide more generalized services through the District Health Office plan, social workers were assigned to the eight Districts and then offered social services on a geographical basis.

In 1919, the first medical social worker in the Department of Public Health was appointed as a "Special Investigator" in the sub-division of Venereal Disease. Her duties were mainly concentrated on follow-up, epidemiological investigations and assistance in the educational programs through talks to social and lay groups. As emphasis on epidemiology, follow-up and education increased, the responsibility for these services seemed to belong to other professional groups, more specifically nursing and medical. Social Workers have

¹ I. Richard R. Verhage, Medical Social Work in A Public Health Setting, Ch. 2.

been replaced by nurse epidemiologists and though medical social service is still available, it is given through the social service staff of the local hospital where the state-aided venereal disease clinic is located.²

From the inception of the Cancer Section in 1926, the Department included a social worker from Pondville Hospital and the state-aided clinic program. The Cancer Division thought of social service mainly as a follow-up service. With the expansion of services to include three workers at Pondville Hospital and two workers at Westfield, the activities of the social worker also broadened to parallel the activities of social workers in general hospitals, namely to provide casework services to patients and their families, with secondary responsibility for follow-up.³

In 1929, two social workers were assigned to the Tuberculosis Division. It was felt that there was need for some sort of discharge planning for tuberculosis patients, in order to prevent recurrences of tuberculosis due to poor and inadequate home conditions. Services were at first limited to children at North Reading, Westfield, and Lakeville State Sanatoria. Social workers brought valuable information regarding social and environmental factors of the

² Helen Almy and Catherine Casey, "Public Health Social Work," Commonhealth, Dec., 1953, pp. 2-6.

³ Ibid.

been replaced by nurse epidemiologists and though medical social service is still available, it is given through the social service staff of the local hospital where the state-aided venereal disease clinic is located.²

From the inception of the Cancer Section in 1936, the Department included a social worker from Bondville Hospital and the state-aided clinic program. The Cancer Division thought of social service mainly as a follow-up service. With the expansion of services to include three workers at Bondville Hospital and two workers at Westfield, the activities of the social worker also broadened to parallel the activities of social workers in general hospitals, namely, to provide casework services to patients and their families, with secondary responsibility for follow-up.³

In 1939, two social workers were assigned to the Tuberculosis Division. It was felt that there was need for some sort of discharge planning for tuberculosis patients, in order to prevent recurrences of tuberculosis due to poor and inadequate home conditions. Services were at first limited to children at North Reading, Westfield, and Lakeville State Sanatoria. Social workers brought valuable information regarding social and environmental factors of the

² Helen Almy and Catherine Casey, "Public Health Social Work," *Community Health*, Dec., 1953, pp. 2-6.

³ *Ibid.*

patients' background to the sanatorium superintendent which was helpful in determining discharge plans. In the 1930 annual report, Dr. Alton S. Pope, Director of the Division of Tuberculosis pointed out that experience showed how social and emotional factors were associated with prevention of TB, and with the treatment and rehabilitation of the patient. Between 1933 and 1948, social workers were placed in all of the sanatoriums.⁴

With the enactment of the Social Security Act in 1936, provision was made under Titles V and VI for expanded services to mothers and children and to crippled children with the aid of funds from the United States Children's Bureau. A plan was submitted by the state to the Children's Bureau for participation in the Federal-State program for Crippled Children and Maternal and Child Health Services. This plan provided for four social workers in the Crippled Children's program attached to the Division of Administration and under which the program was originally placed. In 1940, a social worker was appointed to the Division of Child Hygiene, now known as the Division of Maternal and Child Health.⁵

It is evident that until 1940, the Department concentrated mainly on the treatment of special diseases that were of community concern because of high morbidity and mortality

4. Ibid.

5. Ibid.

patients' background to the sanatorium superintendent which was helpful in determining discharge plans. In the 1930 annual report, Dr. Alton S. Pope, Director of the Division of Tuberculosis pointed out that experience showed how social and emotional factors were associated with prevention of TB, and with the treatment and rehabilitation of the patient. Between 1933 and 1948, social workers were placed in all of the sanatoriums.⁴

With the enactment of the Social Security Act in 1936, provision was made under Titles V and VI for expanded services to mothers and children and to crippled children with the aid of funds from the United States Children's Bureau. A plan was submitted by the state to the Children's Bureau for participation in the Federal-State program for Crippled Children and Maternal and Child Health Services. This plan provided for four social workers in the Crippled Children's program attached to the Division of Administration and under which the program was originally placed. In 1940, a social worker was appointed to the Division of Child Hygiene, now known as the Division of Maternal and Child Health.⁵

It is evident that until 1940, the Department concentrated mainly on the treatment of special diseases that were of community concern because of high morbidity and mortality

4. Ibid.

5. Ibid.

rates, and services were administered through Divisions in the Department setup for this purpose. In 1940, the District Health plan was instituted, by which services became more generalized on a geographical basis. There was more attention given to preventing diseases and promoting health in general. There were eight of these Districts set up throughout the state. In 1943, social workers were assigned to the District offices. This new plan meant that the District social worker was responsible for providing social service for all Department programs. It also meant that, within the unit of the District Health office, she was able to have a closer working relationship with her fellow team members in the District, and with local health and welfare agencies. This same District plan is now in operation. In addition to those social workers assigned to the eight District Health offices, there are those assigned to the institutions under the administration of the Department of Public Health: Rutland and Westfield Sanatoria; North Reading Sanatorium; Pondville Hospital and Lakeville Sanatorium. All social workers, whether assigned to the District offices or to an institution, are administratively responsible to the administrative head of their unit, the District Health Officer or Superintendent of the institution, and technically responsible to the Chief of the Social Work Section.

In the District office, the activity of the public health

rates, and services were administered through Divisions in the Department setup for this purpose. In 1940, the District Health plan was initiated, by which services became more generalized on a geographical basis. There was more attention given to preventing diseases and promoting health in general. There were eight of these Districts set up throughout the state. In 1943, social workers were assigned to the District offices. This new plan meant that the District social worker was responsible for providing social service for all Department programs. It also meant that within the unit of the District Health office, she was able to have a closer working relationship with her fellow team members in the District, and with local health and welfare agencies. This same District plan is now in operation. In addition to those social workers assigned to the eight District Health offices, there are those assigned to the institutions under the administration of the Department of Public Health: Rutland and Westfield Sanatoria; North Reading Sanatorium; Pomfret Hospital and Lakeville Sanatorium. All social workers, whether assigned to the District offices or to an institution, are administratively responsible to the administrative head of their unit, the District Health Officer or Superintendent of the institution, and technically responsible to the Chief of the Social Work Section. In the District office, the activity of the public health

social worker falls into the following four areas:

1. Services to individuals: including casework services to patients and their families, and consultation to other professional workers.
2. Program planning, policy making and standard setting: through direct participation or consultation with others.
3. Community planning: through direct participation or consultation with others.
4. Educational activities: direct education of the various disciplines and consultation with others.
5. Studies, surveys and research⁶

The District social worker is responsible for helping to carry out the various programs of the Department of Public Health. Among the programs requiring the services of a social worker is Services for Crippled Children.

Since the inception of Services for Crippled Children in 1936, the Division of Maternal and Child Health of the Massachusetts Department of Public Health has cared for over ten thousand children.⁷ Under Services for Crippled Children, any child under twenty-one years of age having a crippling condition as defined by the state may receive free diagnostic care in the Crippled Children's clinics.

"In Massachusetts, the 'crippled child' is defined as

⁶ Ibid.

⁷ Dr. Janice Rafuse, "New Hope for the Crippled Child," Commonwealth, Massachusetts Department of Public Health, May, 1953, p.3.

social worker falls into the following four areas:

1. Services to individuals; including casework services to patients and their families, and consultation to other professional workers.
2. Program planning, policy making and standard setting; through direct participation or consultation with others.
3. Community planning; through direct participation or consultation with others.
4. Educational activities; direct education of the various disciplines and consultation with others.
5. Studies, surveys and research.

The District social worker is responsible for helping to carry out the various programs of the Department of Public Health. Among the programs requiring the services of a social worker is Services for Crippled Children. Since the inception of Services for Crippled Children in 1936, the Division of Maternal and Child Health of the Massachusetts Department of Public Health has cared for over ten thousand children.⁷ Under Services for Crippled Children, any child under twenty-one years of age having a crippling condition as defined by the state may receive free diagnostic care in the Crippled Children's clinics. "In Massachusetts, the 'crippled child' is defined as

6 Ibid.

7 Dr. Janice Rouse, "New Hope for the Crippled Child," Commonwealth, Massachusetts Department of Public Health, May, 1953, p. 3.

including the effects of poliomyelitis, bone and joint tuberculosis, congenital defects, cardiac conditions, and other similar conditions that may lead to crippling."⁸

Services for Crippled Children in Massachusetts includes orthopedic, cardiac and plastic surgery services. There are twelve orthopedic clinics located throughout the state; two rheumatic fever clinics, including services for children with congenital heart defects; and two plastic surgery clinics. Through the clinics the following services are provided: medical and surgical diagnostic and treatment services; laboratory service, including x-ray; provision of appliances, braces, etc.; hospitalization for diagnostic, medical and surgical care; provision and financing of specialized consultative services not provided in the clinic setting; convalescent care, including medical foster home placement; clinic and home follow-up services by the public health nurse, social worker, physiotherapist and nutritionist; speech therapy for children with cerebral palsy and cleft palate; and orthodontia for children with cleft palates. Children are accepted for clinic service on referral from their family physician, to whom a complete report of the clinic findings and recommendations are sent.⁹

⁸ Massachusetts Department of Public Health, Facts About Services for Crippled Children, PH-ML-5-3000.

⁹ Dr. Janice Rafuse, op. cit.

With the exception of the Rheumatic Fever Program, which has a social work supervisor assigned to work exclusively in its two clinics in North Reading and Fitchburg, all other crippled children's clinics, orthopedic and plastic surgery, have assigned to them the public health Social Work Supervisor from the District Health Office in its territory. The social worker sees each new patient on his initial clinic visit. Although, by law, any crippled child under twenty-one, as defined by the law, may receive diagnostic services free of charge, only those patients whose families would be unable financially to provide long-term treatment are accepted for continued treatment in the clinic.

The social worker, in seeing the patient and his family on their first visit to the clinic, determines whether the patient is eligible to receive continued service. The social worker determines financial eligibility for continued medical treatment by evaluating what the family income is, what expenses the family has to meet, and whether the family is or is not able to afford the recommended medical treatment under private care. At the same time, the social worker is able to evaluate what the emotional implications of the illness are, what effects the illness may have on the patient and his family and whether the patient would be able to follow through on treatment. "Social casework services in these programs as in the hospital are concerned with problems

With the exception of the Rheumatic Fever Program, which has a social work supervisor assigned to work exclusively in its two clinics in North Reading and Pittsburg, all other crippled children's clinics, orthopedic and plastic surgery, have assigned to them the public health Social Work Supervisor from the District Health Office in its territory. The social worker sees each new patient on his initial clinic visit. Although, by law, any crippled child under twenty-one, as defined by the law, may receive diagnostic services free of charge, only those patients whose families would be unable financially to provide long-term treatment are accepted for continued treatment in the clinic.

The social worker, in seeing the patient and his family on their first visit to the clinic, determines whether the patient is eligible to receive continued service. The social worker determines financial eligibility for continued medical treatment by evaluating what the family income is, what expenses the family has to meet, and whether the family is or is not able to afford the recommended medical treatment under private care. At the same time, the social worker is able to evaluate what the emotional implications of the illness are, what effects the illness may have on the patient and his family and whether the patient would be able to follow through on treatment. "Social casework services in these programs as in the hospital are concerned with problems

which effect health, grow out of illness or interfere with attaining maximum benefits from health services and medical care."¹⁰

Because of the nature of the crippled children's clinics, there are certain problems encountered by the social worker in offering casework services. Because of large caseloads distributed over a wide geographical area, and itinerant clinics offering the opportunity to be in a community for only a brief period of time, the social worker assigned to these clinics must be especially skilled in all areas of casework. She must be readily able to establish a good relationship with the patient and his family; be skilled in making an accurate medical-social diagnosis; and able to make use of social resources in the community, all within a limited amount of time. She must also be skillful in the use of consultation, since on the basis of casework judgment it may seem more feasible to offer service indirectly through consultation with another professional person working directly with the patient and his family. Factors entering into a decision for consultation rather than direct casework service might be undue pressures because

¹⁰ Edith Baker and Doris Siegel, Medical Social Services for Children, U. S. Department of Health, Education and Welfare, Children's Bureau, 1953.

which effect health, grow out of illness or interfere with
attaining maximum benefits from health services and medical
care. 10

Because of the nature of the crippled children's clinics,
there are certain problems encountered by the social worker
in offering casework services. Because of large caseloads
distributed over a wide geographical area, and itinerant
clinics offering the opportunity to be in a community for
only a brief period of time, the social worker assigned to
these clinics must be especially skilled in affairs of
casework. She must be readily able to establish a good
relationship with the patient and his family; be skilled
in making an accurate medical-social diagnosis; and able
to make use of social resources in the community, all within
a limited amount of time. She must also be skillful in
the use of consultation, since on the basis of casework
judgment it may seem more feasible to offer service
indirectly through consultation with another professional
person working directly with the patient and his family.
Factors entering into a decision for consultation rather
than direct casework service might be undue pressures because

10 Edith Baker and Doris Stager, Medical Social
Services for Children, U. S. Department of Health, Education
and Welfare, Children's Bureau, 1953.

of a heavy caseload, greater accessibility to the patient on the part of the consultee, or an already established relationship.

Thus, we see, in summary, that initially the social worker in the Massachusetts Department of Public Health was concerned with offering services to specialized disease groupings, but with the development of the District system, the public health social worker assigned to a particular district was expected to provide service for all Department programs within her district. Among these programs is Services for Crippled Children, which includes three types of clinics: orthopedic, plastic surgery and rheumatic fever, including a congenital heart program. The social worker assigned to a crippled children's clinic has the responsibility for seeing all new patients, determining eligibility for continued care, and offering casework services in those instances where social or emotional factors seem to be affecting an individual's health or interfering with his acceptance of his illness or medical treatment, and where problems arise with the patient or family as a result of the illness. Patients may be referred by the clinic social worker to other social resources equipped to provide specialized services that the Department is unable to offer. One of the social agencies that has been used for the convalescent care of patients from all

of a heavy caseload, greater accessibility to the patient on the part of the consultant, or an already established relationship.

Thus, we see, in summary, that initially the social worker in the Massachusetts Department of Public Health was concerned with offering services to specialized disease groupings, but with the development of the District system, the public health social worker assigned to a particular district was expected to provide service for all Department programs within her district. Among these programs is Services for Crippled Children, which includes three types of clinics: orthopedic, plastic surgery and rheumatic fever, including a congenital heart program. The social worker assigned to a crippled children's clinic has the responsibility for seeing all new patients, determining eligibility for continued care, and offering casework services in those instances where social or emotional factors seem to be affecting an individual's health or interfering with his acceptance of his illness or medical treatment, and where problems arise with the patient or family as a result of the illness. Patients may be referred by the clinic social worker to other social resources equipped to provide specialized services that the Department is unable to offer. One of the social agencies that has been used for the convalescent care of patients from all

three types of clinics is Children's Mission to Children, a child-placing agency that places for convalescent care children with medical handicaps.

Children's Mission to Children, a unit of the Children's Medical Center, is a private non-sectarian child-placing agency specializing in the care of children in need of convalescent care. The agency was founded in 1849 by Fannie Merrill, nine year old daughter of a Unitarian Sunday School teacher in Boston. Fannie became interested in forming a children's club that she was sure would help other children who were in need. Funds raised by children in Unitarian Sunday Schools established the club that became Children's Mission to Children. Even today, it is a tradition for Unitarian Sunday Schools to raise money at Easter in order to contribute to the Children's Mission.

A home was established on Tremont Street where abandoned children and those whose parents were unable to keep them were given shelter. Some of the children were adopted, some stayed at the institution until they were of working age, and some returned to their families. Children's Mission, therefore, in its early days was primarily interested and concerned with keeping neglected children out of the streets. This is indicated by the following passage from an early annual report:

...to create a special mission to the poor, ignorant, neglected children of this city; to gather them into

CHAPTER III

HISTORY AND PHILOSOPHY OF CHILDREN'S MISSION TO CHILDREN

Children's Mission to Children, a unit of the Children's Medical Center, is a private non-sectarian child-placing agency specializing in the care of children in need of convalescent care. The agency was founded in 1849 by Fannie Merrill, nine year old daughter of a Unitarian Sunday School teacher in Boston. Fannie became interested in forming a children's club that she was sure could help other children who were in need. Funds raised by children in Unitarian Sunday Schools established the club that became Children's Mission to Children. Even today, it is a tradition for Unitarian Sunday Schools to raise money at Easter in order to contribute to the Children's Mission.

A home was established on Tremont Street where abandoned children and those whose parents were unable to keep them were given shelter. Some of the children were adopted, some stayed at the institution until they were of working age, and some returned to their families. Children's Mission, therefore, in its early days was primarily interested and concerned with keeping neglected children out of the streets. This is indicated by the following passage from an early annual report:

...to create a special mission to the poor, ignorant, neglected children of this city; to gather them into

HISTORY AND PHILOSOPHY OF CHILDREN'S MISSION TO CHILDREN

Children's Mission to Children, a unit of the Children's Medical Center, is a private non-sectarian child-placing agency specializing in the care of children in need of convalescent care. The agency was founded in 1848 by Fannie Merrill, nine year old daughter of a Unitarian Sunday School teacher in Boston. Fannie became interested in forming a children's club that she was sure could help other children who were in need. Funds raised by children in Unitarian Sunday Schools established the club that became Children's Mission to Children. Even today, it is a tradition for Unitarian Sunday Schools to raise money at Easter in order to contribute to the Children's Mission.

A home was established on Tremont Street where abandoned children and those whose parents were unable to keep them were given shelter. Some of the children were adopted, some stayed at the institution until they were of working age, and some returned to their families. Children's Mission, therefore, in its early days was primarily interested and concerned with keeping neglected children out of the streets. This is indicated by the following passage from an early annual report:

...to create a special mission to the poor, ignorant, neglected children of this city; to gather them into

day and Sunday Schools; to procure places and employment for them, and generally to adopt and pursue such measures as would be most likely to save or rescue them from vice, ignorance and degradation.¹

As the years went by, the agency realized that an institution was not the most suitable substitute for a child's own home, and beginning in 1900 children were boarded in private homes. Children's Mission pioneered actually in modern child welfare practices and was one of the first agencies to change from the use of institutional care to foster home care. Since the early beginnings of foster home care, the present day methods of carefully studying a child, his problems and his needs, and the careful selection of a foster home in accordance with the individual needs of the child were practiced. As early as 1914, Children's Mission began to show the application of modern trends of child placement as described in the following report:

Foster homes are most carefully selected, and approved and classified as to the special type of child to be received. We usually pay board for those children not old enough to earn their own way, and keep them under our close control... Almost all who apply ask that the child be received into charge, but it is our plan to contrive that wholesome families be kept intact,

¹ William Crosby, Superintendent's Annual Report, May, 1889. "The Fiftieth Annual Report of the Children's Mission to the Children of the Destitute," p. 11.

day and Sunday Schools; to procure places and employment for them, and generally to adopt and pursue such measures as would be most likely to save or rescue them from vice, ignorance and degradation.

As the years went by, the agency realized that an institution was not the most suitable substitute for a child's own home, and beginning in 1900 children were boarded in private homes. Children's Mission pioneered actually in modern child welfare practices and was one of the first agencies to change from the use of institutional care to foster home care. Since the early beginnings of foster home care, the present day methods of carefully studying a child, his problems and his needs, and the careful selection of a foster home in accordance with the individual needs of the child were practiced. As early as 1914, Children's Mission began to show the application of modern trends of child placement as described in the following report:

Foster homes are most carefully selected, and approved and classified as to the special type of child to be received. We usually pay board for those children not old enough to earn their own way, and keep them under our close control... Almost all who apply ask that the child be received into charge, but it is our plan to continue that wholesome families be kept intact,

I William Grosby, Superintendent's Annual Report, May, 1932. "The Fifth Annual Report of the Children's Mission to the Children of the District," p. 11.

whenever possible, and striking at the cause of the difficulty, we aim at its correction.²

In the same year, 1914, Dr. Richard Cabot, who helped to organize the social service department of the Massachusetts General Hospital, became concerned with the fact that many children who required long hospitalization became "institutionalized" and retarded in their physical and social development. He felt that recovery might be more rapid either in their own home or in foster homes and requested that Children's Mission place sick children for convalescent care, which eventually became the main specialized function of the agency.

Gradually, the Children's Mission accepted more and more referrals from hospitals and social agencies of children who were medically handicapped and in need of convalescent care that could not adequately be provided in their own home. In the Seventy-Sixth Annual Report of 1925, the work of the agency is more clearly defined:

During the past year, we have dealt with 379 applications; representing the needs of 482 children, and in each instance, it has developed upon us to extricate our clients from their entanglements, to see that peculiar needs are met by specialists, and to provide that form of help which we are specially equipped to render.

In our foster homes, where children are cared for under our close supervision, we have provided

² Parker B. Field, "Report of the General Secretary, "The Sixty-Fifth Annual Report of the Children's Mission to Children," pp.13-14

whenever possible, and striking at the cause of the difficulty, we aim at its correction.²

In the same year, 1914, Dr. Richard Gabot, who helped to organize the social service department of the Massachusetts General Hospital, became concerned with the fact that many children who required long hospitalization became "institutionalized" and retarded in their physical and social development. He felt that recovery might be more rapid either in their own home or in foster homes and requested that Children's Mission place sick children for convalescent care, which eventually became the main specialized function of the agency. Gradually, the Children's Mission accepted more and more referrals from hospitals and social agencies of children who were medically handicapped and in need of convalescent care that could not adequately be provided in their own home. In the Seventy-Sixth Annual Report of 1925, the work of the agency is more clearly defined:

During the past year, we have dealt with 379 applications; representing the needs of 482 children, and in each instance, it has developed upon us to extricate our clients from their entanglements, to see that peculiar needs are met by specialists, and to provide that form of help which we are specially equipped to render.

In our foster homes, where children are cared for under our close supervision, we have provided

² Parker B. Field, "Report of the General Secretary, The Sixty-Fifth Annual Report of the Children's Mission to Children," pp. 12-14

for 233 children of all ages, and of race and faith without restriction. Here their parents have visited them and we have encouraged return of the children as soon as we are sure that the conditions of both child and home would permit such a course.

Our methods, in brief, are as follows: First there is an exhaustive study of the situation and of the child, with object the correction of the difficulty without the removal of the child. If the child must be removed, we take great pains to select from our approved and classified foster homes one of the faith of the child which just fits the particular need. Next comes the placement of the child in its new environment with as little disturbance as possible. Then follow weeks, months, or even years of oversight by a devoted visitor who assumes the function of a guardian of the child and friend of the family which may, itself, need rehabilitation. This continues until some time after the child, with the handicap removed has returned to his own kin.³

The Children's Mission became increasingly known as a medical child-placing agency, and has continued as such to the present day. Until recently, the major illness seen in children under care was rheumatic fever, but during the past year, 1953, the agency cared for 228 children with sixty-seven different diagnoses, some of these children having multiple handicaps. In general, only those children with a good prognosis are accepted for placement. In addition to the various medical diagnoses that are accepted, the agency is increasingly receiving requests for placement of emotionally disturbed children who have some medical defect, but where it is difficult to evaluate the medical

³ Parker B. Field, "Report of the General Secretary." The Seventy-Sixth Annual Report of the Children's Mission to Children, pp. 5-6

for 228 children of all ages, and of race and faith without restriction. Here their parents have visited them and we have encouraged return of the children as soon as we are sure that the conditions of both child and home would permit such a course.

Our methods, in brief, are as follows: First there is an exhaustive study of the situation and of the child, with object the correction of the difficulty without the removal of the child. If the child must be removed, we take great pains to select from our approved and classified foster homes one of the faith of the child which just fits the particular need. Next comes the placement of the child in its new environment with as little disturbance as possible. Then follow weeks, months, or even years of oversight by a devoted visitor who assumes the function of a guardian of the child and friend of the family which may, itself, need rehabilitation. This continues until some time after the child, with the handicap removed has returned to his own kin.

The Children's Mission became increasingly known as a medical child-placing agency, and has continued as such to the present day. Until recently, the major illness seen in children under care was rheumatic fever, but during the past year, 1953, the agency cared for 228 children with sixty-seven different diagnoses, some of these children having multiple handicaps. In general, only those children with a good prognosis are accepted for placement. In addition to the various medical diagnoses that are accepted, the agency is increasingly receiving requests for placement of emotionally disturbed children who have some medical defect, but where it is difficult to evaluate the medical

condition while the child remains in his own home.⁴

Referrals come from a wide variety of sources: from hospital social service departments, public and private social agencies, visiting nurses, private physicians, clergy and families. A medical and social history is obtained from the referring agency, after which the parents are interviewed in order to plan for the child's care. If placement is decided upon, the child is seen and prepared for this by the social worker. The reason for placement is explained to the child in terms that he can understand. Before the child is placed, the child's legal guardian is asked to sign an agreement form designating what he agrees to pay for the child's board, if he feels he can afford to contribute, and giving the agency permission to hospitalize the child if such an emergency arises. "Parents are urged to accompany the social worker on the placement trip to the foster home, and parents and relatives are urged to visit regularly so that the child will not feel isolated from his family and so that he may more easily fit into his own home again."⁵ While the child is in placement, case-work services are provided for the family so that problems

⁴ The foregoing material was obtained from an unpublished report of Children's Mission to Children.

⁵ Ibid.

condition while the child remains in his own home.⁴

Referrals come from a wide variety of sources: from hospital social service departments, public and private social agencies, visiting nurses, private physicians, clergy and families. A medical and social history is obtained from the referring agency, after which the parents are interviewed in order to plan for the child's care. If placement is decided upon, the child is seen and prepared for this by the social worker. The reason for placement is explained to the child in terms that he can understand. Before the child is placed, the child's legal guardian is asked to sign an agreement form designating what he agrees to pay for the child's board, if he feels he can afford to contribute, and giving the agency permission to hospitalize the child in such an emergency arises. "Parents are urged to accompany the social worker on the placement trip to the foster home, and parents and relatives are urged to visit regularly so that the child will not feel isolated from his family and so that he may more easily fit into his own home again."⁵ While the child is in placement, case-work services are provided for the family so that problems

⁴ The foregoing material was obtained from an unpublished report of Children's Mission to Children.

which prevent the child from being at home can be alleviated.

Foster homes are selected to suit the child's physical and emotional needs. Babies and young children are placed in individual foster homes where they can have attention and affection from substitute parents. These individual foster homes are generally found through newspaper advertisements, married alumnae of schools of nursing, and friends and neighbors of present foster parents. The prospective foster parent is interviewed carefully, often more than once, in order to evaluate what his motivation for wanting a foster child might be, and how his home and family might meet physical and emotional needs of a placed child. Older children are usually placed in group homes that accommodate up to twelve children. A pattern of normal living, in so far as possible, is followed in these group convalescent homes. There are special provisions made, however, for those children who must spend long hours in bed. A school-teacher is provided for those children who have limited time up and are unable to attend school; a religious teacher of the child's faith is provided; and an occupational therapist, laboratory technician, and physician visit regularly. These group homes are also used for those children whose parents cannot face the competition of substitute parents, as represented in an individual foster home, and therefore

which prevent the child from being at home can be alleviated. Foster homes are selected to suit the child's physical and emotional needs. Babies and young children are placed in individual foster homes where they can have attention and affection from substitute parents. These individual foster homes are generally found through newspaper advertisements, married alumni of schools of nursing, and friends and neighbors of present foster parents. The prospective foster parent is interviewed carefully, often more than once, in order to evaluate what his motivation for wanting a foster child might be, and how his home and family might meet physical and emotional needs of a placed child. Older children are usually placed in group homes that accommodate up to twelve children. A pattern of normal living, in as far as possible, is followed in these group convalescent homes. There are special provisions made, however, for those children who must spend long hours in bed. A school-teacher is provided for those children who have limited time up and are unable to attend school; a religious teacher of the child's faith is provided; and an occupational therapist, laboratory technician, and physician visit regularly. These group homes are also used for those children whose parents cannot face the competition of substitute parents, as represented in an individual foster home, and therefore

cannot tolerate the latter type of placement.⁶ In addition, the agency carries on a program of summer placements to provide vacations for handicapped children. The children are usually placed in small group homes in the country. Whenever a child is placed in either an individual or group placement, the foster mother is given information on the child's illness, the reason for placement, a description of the child's personality and interests, and directions for physical care. During placement, there is steady guidance of the foster mother, to interpret the child's needs and behavior to her, and to help her meet these needs.

The staff at Children's Mission consists of a part-time Medical Director; Executive Secretary, Medical Social Consultant; Casework Supervisor; four Caseworkers; a part-time Occupational Therapist; a Case-Aide and four clerical workers.

From this brief summary of the history and philosophy of Children's Mission, we see that it has evolved from an agency that gave generalized child welfare services to one whose specialized function has become the care of medically handicapped children who cannot be cared for in their own homes. It is interesting to note that through the years Children's Mission has had the philosophy that the rightful place for a child is within his own home, but that if he

6 Ibid.

cannot tolerate the latter type of placement.⁶ In addition, the agency carries on a program of summer placements to provide vacations for handicapped children. The children are usually placed in small group homes in the country. Whenever a child is placed in either an individual or group placement, the foster mother is given information on the child's illness, the reason for placement, a description of the child's personality and interests, and directions for physical care. During placement, there is a steady guidance of the foster mother, to interpret the child's needs and behavior to her, and to help her meet these needs.

The staff at Children's Mission consists of a part-time Medical Director; Executive Secretary, Medical Social Consultant; Casework Supervisor; four Caseworkers; a part-time Occupational Therapist; a Case-Aide and four clerical workers.

From this brief summary of the history and philosophy of Children's Mission, we see that it has evolved from an agency that gave generalized child welfare services to one whose specialized function has become the care of medically handicapped children who cannot be cared for in their own homes. It is interesting to note that through the years Children's Mission has had the philosophy that the rightful place for a child is within his own home, but that if he

⁶ Ibid.

cannot receive the care that he needs with his own family, casework services should be provided to the family to

alleviate those with the goal of the child's eventual return to his home.

Social workers, particularly those in the child welfare field, are becoming increasingly aware of the many implications of separating a child from his family through placement away from home. Placement in a foster home is at best only a substitute home, and we cannot expect "to make up to the child for the loss of his own home, or to the parents for the loss of some of their parental responsibilities and satisfactions."¹ The decision for placement should be made only on a sound diagnostic basis, one that makes certain that the child would be unable to satisfy his physical and emotional needs within his own family group. The social worker making the evaluation must weigh the issues, so that she is certain that placement of the child away from his own home is going to be less traumatic than remaining with his own family. In order for the experience of placement to be most beneficial, various factors should be considered.

Bowlby² speaks of the child in the foster home or institution as living in two worlds: the foster home or

1 Ellis K. Radinsky, "While a Child Sleeps or a Foster Home," The Child, March, 1957, pp. 200.

2 Bowlby, John, Maternal Care and Mental Health, WHO, Geneva 1951.

CHAPTER IV

IMPORTANT FACTORS IN THE PLACEMENT OF HANDICAPPED CHILDREN

Social workers, particularly those in the child welfare field, are becoming increasingly aware of the many implications of separating a child from his family through placement away from home. Placement in a foster home is at best only a substitute home, and we cannot expect "to make up to the child for the loss of his own home, or to the parents for the loss of some of their parental responsibilities and satisfactions."¹ The decision for placement should be made only on a sound diagnostic basis, one that makes certain that the child would be unable to satisfy his physical and emotional needs within his own family group. The social worker making the evaluation must weigh the issue, so that she is certain that placement of the child away from his own home is going to be less traumatic than remaining with his own family. In order for the experience of placement to be most beneficial, various factors should be considered.

Bowlby² speaks of the child in the foster home or institution as living in two worlds: the foster home or

¹ Eliz. K. Radinsky, "While a Child Stays in a Foster Home," The Child, March, 1952, pp. 105.

² Bowlby, John, Maternal Care and Mental Health, WHO, Geneva 1951.

CHAPTER IV
IMPORTANT FACTORS IN THE PLACEMENT OF HANDICAPPED CHILDREN

Social workers, particularly those in the child welfare field, are becoming increasingly aware of the many implications of separating a child from his family through placement away from home. Placement in a foster home is at best only a substitute home, and we cannot expect "to make up to the child for the loss of his own home, or to the parents for the loss of some of their parental responsibilities and satisfactions."¹ The decision for placement should be made only on a sound diagnostic basis, one that makes certain that the child would be unable to satisfy his physical and emotional needs within his own family group. The social worker making the evaluation must weigh the issue, so that she is certain that placement of the child away from his own home is going to be less traumatic than remaining with his own family. In order for the experience of placement to be most beneficial, various factors should be considered.

Bowlby² speaks of the child in the foster home or institution as living in two worlds: the foster home or

¹ Ellis K. Radinsky, "While a Child Stays in a Foster Home," The Child, March, 1952, pp. 102.
² Bowlby, John, Maternal Care and Mental Health, WHO, Geneva 1951.

institution as living in two worlds: the foster home or institution and his own home. If it is possible, then, while the child is in placement, he should have frequent contact with the natural parents, and during placement casework services should be offered to the parents so that they can be enabled to bring about the change necessary to make a good home for the child.

Ideally, the pre-placement process should extend over a long enough time so that the child can make the break from his family more easily and so that he can adjust to the prospective foster parents more slowly. Anna Freud has concluded that it does not seem to be so much the fact of separation itself to which the child reacts in an abnormal way, but the traumatic way in which this separation takes place, and the decisive outcome seems to be inherent in the time allowed.³ The child should be told frankly why he is being placed away from his own home and family and what the prospective home will be like, for the child, with a weaker ego than an adult, is likely to exaggerate and fear the unknown. Bowlby says that "...evidence shows that the more actively the child can be helped to participate in the plans being made for him and the more he is helped to understand what they are, for how long they will last and the

³ Anna Freud & Burlingham, War and Children, N. Y. N. Y.: Ernest Willard, 1943, p. 103.

institution as living in two worlds: the foster home or institution and his own home. If it is possible, then, while the child is in placement, he should have frequent contact with the natural parents, and during placement casework services should be offered to the parents so that they can be enabled to bring about the change necessary to make a good home for the child.

Ideally, the pre-placement process should extend over a long enough time so that the child can make the break from his family more easily and so that he can adjust to the prospective foster parents more slowly. Anna Freud has concluded that it does not seem to be so much the fact of separation itself to which the child reacts in an abnormal way, but the traumatic way in which this separation takes place, and the decisive outcome seems to be inherent in the time allowed.⁵ The child should be told frankly why he is being placed away from his own home and family and what the prospective home will be like, for the child, with a weaker ego than an adult, is likely to exaggerate and fear the unknown. Bowlby says that "...evidence shows that the more actively the child can be helped to participate in the plans being made for him and the more he is helped to understand what they are, for how long they will last and the

⁵ Anna Freud & Burlingham, War and Children, N. Y. N. Y.: Ernest Willard, 1942, pp. 108.

reasons for them, the more likely is the placement to be a success."⁴

In addition to fear of the unknown, a frequent meaning of placement for the child is that he feels he is being abandoned, or that placement symbolizes that he is unwanted at home. Placement may also represent punishment to the child for his "bad" impulses. He may feel resentment toward his parents for placement, and guilt as a result of this resentment.

The parent, too, has many feelings about placement and separation that should be understood, and if possible, dealt with. Many parents feel guilty over placing their child, because in our society it is considered the parental responsibility to assume care of one's child. The parent may also feel guilty because either consciously or unconsciously he may be rejecting the child, and placement may symbolize a carrying-out of the rejecting wish to be rid of the child. Because it is the social norm to rear one's own child, the parent may fear loss of status with his child and with the community. Many parents fear loss of control of their child, and that the agency, and in particular the substitute parent, may have more meaning to the child and will assume the natural parents' prerogatives.

⁴ Bowlby, op. cit.

reasons for them, the more likely is the placement to be a success.⁴

In addition to fear of the unknown, a frequent meaning of placement for the child is that he feels he is being abandoned, or that placement symbolizes that he is unwanted at home. Placement may also represent punishment to the child for his "bad" impulses. He may feel resentment toward his parents for placement, and guilt as a result of this resentment.

The parent, too, has many feelings about placement and separation that should be understood, and if possible, dealt with. Many parents feel guilty over placing their child,

because in our society it is considered the parental responsibility to assume care of one's child. The parent may also feel guilty because either consciously or unconsciously he may be rejecting the child, and placement may symbolize a carrying-out of the rejecting wish to be rid of the child. Because it is the social norm to rear one's

own child, the parent may fear loss of status with his child and with the community. Many parents fear loss of control of their child, and that the agency, and in particular the substitute parent, may have more meaning to the child and will assume the natural parents' prerogatives.

⁴ Bowlby, op. cit.

The parent may wonder what sort of care the child will receive in his new home. And, to most parents, placement symbolizes to them their own failure and inadequacy as parents.⁵

In working with the child and parent before and during placement, these feelings must be recognized and, if possible, dealt with in order to help parent and child accept placement, to benefit from it, and to help the family improve those factors in the home and in themselves that made placement necessary. The worker must recognize both the strengths and weaknesses in the natural family, and help the parent use those strengths that he can. The worker must accept the parent as he is, although not condoning what he does. The worker, in helping the parent, must assuage his guilt and anxiety over placement, or else the parent may develop even more intense feelings of guilt and a sense of failure.

In the placement of children in foster homes, there are actually three areas of work that must be considered: work with the parents; work with the child; and work with the foster parents. Part of this work with foster parents is concerned with selection of the foster home to meet the needs of the individual child. In doing this, the worker must be diagnostically certain of the individual needs of the

⁵ The information was obtained through class notes in child-placing course.

The parent may wonder what sort of care the child will receive in his new home. And, to most parents, placement symbolizes to them their own failure and inadequacy as parents.⁵

In working with the child and parent before and during placement, these feelings must be recognized and, if possible, dealt with in order to help parent and child accept placement, to benefit from it, and to help the family improve those factors in the home and in themselves that make placement necessary. The worker must recognize both the strengths and weaknesses in the natural family, and help the parent use those strengths that he can. The worker must accept the parent as he is, although not condoning what he does. The worker, in helping the parent, must assuage his guilt and anxiety over placement, or else the parent may develop even more intense feelings of guilt and a sense of failure.

In the placement of children in foster homes, there are actually three areas of work that must be considered: work with the parents; work with the child; and work with the foster parents. Part of this work with foster parents is concerned with selection of the foster home to meet the needs of the individual child. In doing this, the worker must be diagnostically certain of the individual needs of the

⁵ The information was obtained through class notes in child-placing course.

child, what the motivations of the foster parents might be in accepting a child for placement, what the foster home has to offer this child, how the foster parents would be able to accept continuing guidance from the agency, and how they would be able to accept the natural parents. Since increasingly, child welfare workers are becoming more firmly convinced of the need for continued and frequent contact between the placed child and his natural parent or parents, this latter area can be very important. How is the foster parent going to accept the natural parent with all of his weaknesses, and particularly his feelings around the placement of his child, which often can take the form of projecting his own feelings of guilt onto the foster home by extremely critical behavior of the foster parents, their handling of the child and their home? Before the child is placed, the child-placing worker should include information preparing the foster parents for the child a detailed picture of the child's behavior, both good and bad, and in the case of placements of the medically handicapped, medical information on the child's condition and recommendations that will be of use to the foster family. Also included should be an indication of the child's emotional needs and how they might be met and a simple explanation of why the child is not with his own family.⁶ Anna Freud speaks of the necessity,

6 Ibid.

child, what the motivations of the foster parents might be in accepting a child for placement, what the foster home has to offer this child, how the foster parents would be able to accept continuing guidance from the agency, and how they would be able to accept the natural parents. Since increasingly, child welfare workers are becoming more firmly convinced of the need for continued and frequent contact between the placed child and his natural parent or parents, this latter area can be very important. How is the foster parent going to accept the natural parent with all of his weaknesses, and particularly his feelings around the placement of his child, which often can take the form of projecting his own feelings of guilt onto the foster home by extremely critical behavior of the foster parents, their handling of the child and their home? Before the child is placed, the child-placing worker should include information preparing the foster parents for the child a detailed picture of the child's behavior, both good and bad, and in the case of placements of the medically handicapped, medical information on the child's condition and recommendations that will be of use to the foster family. Also included should be an indication of the child's emotional needs and how they might be met and a simple explanation of why the child is not with his own family.⁶ Anna Freud speaks of the necessity,

⁶ Ibid.

particularly during the latency period, because of family romance fantasies at this time, of placing the child in a foster family of approximately the same social level, for "the fact of being billeted with foster parents of a different social level may be upsetting to the child because it gives sudden and undesired reality to a situation which was meant to be lived out in the realms of fantasy."⁷ The child if urged to adapt himself to a higher level of social behavior, may resent these demands as criticism directed against his parents. If, on the other hand, the child is placed with a family of a lower social and economic level, he may interpret this as punishment for former behavior and ungratefulness at home.⁸

Any social worker who is dealing with illness must understand the meaning of that illness to the patient or client, and the effects that the illness may have on himself and others in his environment. A child's ego does not have the strength to handle anxiety provoked by new and strange experiences, by physical trauma or separation from loved ones, all of which may be involved in illness. He can handle such experiences only with especially strong

⁷ Freud & Burlingham, War and Children, op. cit.

⁸ Ibid.

particularly during the latency period, because of family romance fantasies at this time, of placing the child in a foster family of approximately the same social level, for "the fact of being billeted with foster parents of a different social level may be upsetting to the child because it gives sudden and undesired reality to a situation which was meant to be lived out in the realm of fantasy."⁷ The child is urged to adapt himself to a higher level of social behavior, may resent these demands as criticism directed against his parents. If, on the other hand, the child is placed with a family of a lower social and economic level, he may interpret this as a punishment for former behavior and ungratefulness at home.⁸

Any social worker who is dealing with illness must understand the meaning of that illness to the patient or client, and the effects that the illness may have on him-self and others in his environment. A child's ego does not have the strength to handle anxiety provoked by new and strange experiences, by physical trauma or separation from loved ones, all of which may be involved in illness. He can handle such experiences only with especially strong

⁷ Freud & Burlingham, War and Children, op. cit.

⁸ Ibid.

support from those in his environment.⁹ Senn says that the emotional response of a sick child to his illness and convalescence is dependent on six main factors: the physical, intellectual and psychological status of the individual at the onset of his illness; the nature of the illness; the type, severity, and duration of his symptoms; the length of convalescence and amount and kind of physical residua; his pre-existing feelings about his body, health and life in general; and the interpersonal relationship with those taking care of him.¹⁰

Anna Freud speaks of several factors that may determine the after-effects of the illness. The parent or another individual who is caring for the child during his illness may have an entirely different attitude toward the child when he is ill than when he is well. The ill child may find himself more loved and indulged by his parents because of their own anxiety about the illness. It may be difficult for the child who is treated in this way to renounce the secondary gains that he has enjoyed through the illness. Also, because of the dependent position that the child is forced into as a result of his illness, he may on the one hand give in to this enforced regression so that he regresses

⁹ Upham, Frances, Dynamic Approach to Illness, p. 67.

¹⁰ Senn, Milton, "Emotional Aspects of Convalescence," The Child, 10:24, 1945.

support from those in his environment.⁹ Senn says that the emotional response of a sick child to his illness and convalescence is dependent on six main factors: the physical, intellectual and psychological status of the individual at the onset of his illness; the nature of the illness; the type, severity, and duration of his symptoms; the length of convalescence and amount and kind of physical rest; his pre-existing feelings about his body, health and life in general; and the interpersonal relationship with those taking care of him.¹⁰

Anna Freud speaks of several factors that may determine the after-effects of the illness. The parent or another individual who is caring for the child during his illness may have an entirely different attitude toward the child when he is ill than when he is well. The ill child may find himself more loved and indulged by his parents because of their own anxiety about the illness. It may be difficult for the child who is treated in this way to renounce the secondary gains that he has enjoyed through the illness. Also, because of the dependent position that the child is forced into as a result of his illness, he may on the one hand give in to this enforced regression so that he regresses

⁹ Uphan, Frances, Dynamic Approach to Illness, p. 67.

¹⁰ Senn, Milton, "Emotional Aspects of Convalescence," The Child, 10:24, 1945.

to a state of helpless infancy, or on the other hand, builds up strong defenses against dependency and becomes a difficult, intractable patient. The restrictive measures that are used during the illness may be seen by him as punishment, since when he is well these same measures may actually be used as punishment. Surgical intervention or any method using instrumentation may activate or reactivate fears of attack or castration in the child. One must understand that the meaning of this sort of experience is not dependent on the severity of the measure but on the type of fantasies that it provokes. For example, pain which may be concomitant with the illness or the treatment may arouse anxiety or other feelings that surround the child's unconscious fantasies, such as anger, revenge feelings, masochistic submission or guilt or depression. Hypochondria itself may develop as a result of the mother's extreme over-protection and concern about certain areas of the child's body.¹¹

One sees then from the literature that there may be various reactions of the child and the members of his environment to his illness, reactions which may be transitory or which may have a more lasting effect. These may be briefly summarized as over-protection and over-solicitude on the part of the parents; guilt feelings that their child

¹¹ Anna Freud, "Role of Bodily Illness in the Mental Life of Children," Psychoanalytical Study of the Child, 7:69, 1953

to a state of helpless infancy, or on the other hand, builds up strong defenses against dependency and becomes a difficult, intractable patient. The restrictive measures that are used during the illness may be seen by him as punishment, since when he is well these same measures may actually be used as punishment. Surgical intervention or any method raising instrumentation may activate or reawaken fears of attack or castration in the child. One must understand that the meaning of this sort of experience is not dependent on the severity of the measure but on the type of fantasies that it provokes. For example, pain which may be concomitant with the illness or the treatment may arouse anxiety or other feelings that surround the child's unconscious fantasies, such as anger, revenge feelings, masochistic submission or guilt or depression. Hypochondria itself may develop as a result of the mother's extreme over-protection and concern about certain areas of the child's body. 11

One sees then from the literature that there may be various reactions of the child and the members of his environment to his illness, reactions which may be transitory or which may have a more lasting effect. These may be briefly summarized as over-protection and over-solicitude on the part of the parents; guilt feelings that their child

has become ill, or has a congenital handicap; or a feeling that this was punishment for their own misdeeds or mishandling of the child. The child, in return, may sense this different attitude toward him, may become bewildered by it, or take advantage of this attitude and find pleasure in the secondary gain from his illness. The child may, under the enforced dependency that illness may necessitate, regress to a more infantile stage, or may rebel and become a most difficult "uncooperative" patient. He may view the illness itself, but particularly any surgical measure or any treatment using instruments, as punishment, attack, reacting with unconscious castration fears, particularly in the boy. The child may in some cases turn the direction of the libido from the outside onto some particular area of the body, developing an attitude of chronic hypochondria.

In the placement of the sick child, the worker who is doing the referring and the child-placing worker must be aware of attitudes that the child and his family might have toward both the placement itself and to his illness; for the child to make the most beneficial adjustment in the long run, these attitudes in both areas should be dealt with. This is particularly true with the child who has a handicap that may be more or less chronic in nature. Actually, in some cases, foster home placement may intensify feelings of guilt already present in the parent as a result of the

has become ill, or has a congenital handicap; or a feeling that this was punishment for their own misdeeds or mis-handling of the child. The child, in return, may sense this different attitude toward him, may become bewildered by it, or take advantage of this attitude and find pleasure in the secondary gain from his illness. The child may, under the enforced dependency that illness may necessitate, regress to a more infantile stage, or may rebel and become a most difficult "uncooperative" patient. He may view the illness itself, but particularly any surgical measure or any treatment using instruments, as punishment, attack, reacting with unconscious castration fears, particularly in the boy. The child may in some cases turn the direction of the libido from the outside onto some particular area of the body, developing an attitude of chronic hypochondria. In the placement of the sick child, the worker who is doing the referring and the child-placing worker must be aware of attitudes that the child and his family might have toward both the placement itself and to his illness; for the child to make the most beneficial adjustment in the long run, these attitudes in both areas should be dealt with. This is particularly true with the child who has a handicap that may be more or less chronic in nature. Actually, in some cases, foster home placement may intensify feelings of guilt already present in the parent as a result of the

physical handicap. In other cases, placement may appear far more tolerable to the parent of an ill child than if that child were well, although the child might exhibit the same behavior and the family the same unstable environment, whether the child is well or sick. The handicap would then serve as a legitimate, socially acceptable excuse for placing the child, and therefore, the parent would not be burdened with severe guilt feelings. However, at the same time, it might be difficult to expect much change in these parents, for they would not be seeing themselves or the actual reason for placement realistically. Perhaps, it might be wise to inform the reader here that in the placement of medically handicapped children, it is often difficult to allow sufficient time to prepare the child, parent and foster home for the placement, since there are often very realistic pressures from the hospital to have the child discharged and into convalescent facilities.

The manner in which the family and the agency are prepared for the referral is an important consideration. A recent study by a committee of the United Community Services of Greater Boston¹² on procedures to be used in referrals and working relationships between social service departments in

¹² Council on Social Work in Medical Care, Committee on Interagency Relationships.

physical handicap. In other cases, placement may appear far more tolerable to the parent of an ill child than it that child were ill, although the child might exhibit the same behavior and the family the same unstable environment, whether the child is well or sick. The handicap would then serve as a legitimate, socially acceptable excuse for placing the child, and therefore, the parent would not be burdened with severe guilt feelings. However, at the same time, it might be difficult to expect much change in these parents, for they would not be seeing themselves or the actual reason for placement realistically. Perhaps, it might be wise to inform the reader here that in the placement of medically handicapped children, it is often difficult to allow sufficient time to prepare the child, parent and foster home for the placement, since there are often very realistic pressures from the hospital to have the child discharged and into convalescent facilities.

The manner in which the family and the agency are prepared for the referral is an important consideration. A recent study by a committee of the United Community Services of Greater Boston¹² on procedures to be used in referrals and working relationships between social service departments in

¹² Council on Social Work in Medical Care, Committee on Interagency Relationships.

hospitals and social agencies defined three steps that seem to be necessary in making a referral to another agency: getting the patient receptive to the referral; getting the agency receptive to the referral of the patient; and getting the patient to the referral agency. Before the referral is made, there should be clear diagnostic thinking on the part of the hospital social worker as to the patient's problem and the need for referral. The patient should participate in the referral process, understand and accept the reason for referral. The reason for the referral should be clear to the referral agency, and there should be a clear definition of casework responsibility between the agencies at the point of referral.

In the conclusion, the writer would like to quote Ethel Verry, Director of Chicago Orphan Asylum, from a speech made at a conference on convalescent care for children held at Hershey, Pennsylvania, April 19-20, 1945.

No one, at least no one who is informed or who has given any thought to the matter, would dispute the fact that the best place for the sick child to get well, as soon as he can get along without the highly skilled medical and nursing service and formal treatment available only in the hospital or institution, is in his own home. Since that fact is so obvious, the basic reason for convalescent care in any community should be in the form of service and aid to the children's family so that whenever it is at all possible the child can get the care that he needs, when he needs it, in his own home. But in a world where families live under housing conditions as deplorable as now exist in many communities, where mothers work outside the home and place their youngsters for long hours in nursery groups or day-care

hospitals and social agencies defined three steps that seem to be necessary in making a referral to another agency: getting the patient receptive to the referral; getting the agency receptive to the referral of the patient; and getting the patient to the referral agency. Before the referral is made, there should be clear diagnostic thinking on the part of the hospital social worker as to the patient's problem and the need for referral. The patient should participate in the referral process, understand and accept the reason for referral. The reason for the referral should be clear to the referral agency, and there should be a clear definition of casework responsibility between the agencies at the point of referral.

In the conclusion, the writer would like to quote Ethel Verry, Director of Chicago Orphan Asylum, from a speech made at a conference on convalescent care for children held at Hershey, Pennsylvania, April 19-20, 1945.

No one, at least no one who is informed or who has given any thought to the matter, would dispute the fact that the best place for the sick child to get well, as soon as he can get along without the highly skilled medical and nursing service and formal treatment available only in the hospital or institution, is in his own home. Since that fact is so obvious, the basic reason for convalescent care in any community should be in the form of service and aid to the children's family so that whenever it is at all possible the child can get the care that he needs, when he needs it, in his own home. But in a world where families live under housing conditions as deplorable as now exist in many communities, where workers work outside the home and place their youngsters for long hours in nursery groups or day-care

homes, where strained and unhappy and unhealthy family relationships and parental attitudes defy the skill of caseworker and psychiatrist, there are sure to be children who, although they do get along somehow in their homes when they are well, simply cannot get well under the same conditions. The recognition of such situations, the diagnosis, if you will, of the need for foster home placement as a convalescent measure, calls for a very wise and skillful weighing of the medical and social and emotional factors in each situation if serious mistakes in planning, with subsequent harm to the child, not to mention waste of community resources, are to be avoided.¹³

¹³ Allen, Kathleen, "Caring for Convalescent Children," The Child 10:3, 1945.

The aim of the study is to evaluate whether there was in the eleven cases studied a relationship between the adequacy of pre-placement planning and preparation and the degree of success of the placement. The cases have been classified according to the degree of successful adjustment to foster home placement.

The following four cases adjusted successfully to placement. A successful adjustment is defined as one in which the child exhibited no psychoneurotic symptoms or behavior disturbances at any time during placement, or if such symptoms were exhibited in the initial weeks of placement, they disappeared after this phase and no further symptoms were seen.

Of these four children, three were girls and one a boy, the oldest of these nine years, the youngest twelve

CHAPTER V

FOUR CASES OF CHILDREN WHOSE ADJUSTMENTS TO PLACEMENT
WERE SUCCESSFUL

One can see from the foregoing chapter that there are many emotional reactions that both parents and the child may have to separation and to placement itself. From the literature, it is suggested that placement is more successful if the decision for placement is made on a sound diagnostic basis, and if the emotional reactions of both parents and child are considered before placement is made. The aim of the study is to evaluate whether there was in the eleven cases studied a relationship between the adequacy of pre-placement planning and preparation and the degree of success of the placement. The cases have been classified according to the degree of successful adjustment to foster home placement.

The following four cases adjusted successfully to placement. A successful adjustment is defined as one in which the child exhibited no psychoneurotic symptoms or behavior disturbances at any time during placement, or if such symptoms were exhibited in the initial weeks of placement, they disappeared after this phase and no further symptoms were seen.

Of these four children, three were girls and one a boy, the oldest of these nine years, the youngest twelve

CHAPTER V
FOUR CASES OF CHILDREN WHOSE ADJUSTMENTS TO PLACEMENT
WERE SUCCESSFUL

One can see from the foregoing chapter that there are many emotional reactions that both parents and the child may have to separation and to placement itself. From the literature, it is suggested that placement is more successful if the decision for placement is made on a sound diagnostic basis, and if the emotional reactions of both parents and child are considered before placement is made. The aim of the study is to evaluate whether there was in the eleven cases studied a relationship between the adequacy of pre-placement planning and preparation and the degree of success of the placement. The cases have been classified according to the degree of successful adjustment to foster home placement.

The following four cases adjusted successfully to placement. A successful adjustment is defined as one in which the child exhibited no psychoneurotic symptoms or behavior disturbances at any time during placement, or if such symptoms were exhibited in the initial weeks of placement, they disappeared after this phase and no further symptoms were seen.

Of these four children, three were girls and one a boy, the oldest of these nine years, the youngest twelve

months. Two of the children were referred for placement because of the mother's inability to supervise their convalescence from rheumatic fever due to her own ill health. A third child was referred because of hyperactivity which his deaf mute parents were unable to supervise and control. The fourth, a child with multiple handicaps, was referred for placement because of her mother's terminal illness and inability to give adequate care to the child. In all of these cases, there was extensive planning and preparation for the placement by both the referring worker and the child-placing worker.

Before his serious illness, Carl had been a normal boy, except for delayed speech. It was the vaccination to public school kindergarten when Carl was four that precipitated the encephalomyelitis. Within two days of the vaccination, he complained of not feeling well, vomited, had convulsions on the left side, and went into a coma with a temperature of 107° which lasted several days. Carl was admitted to a local hospital and then transferred to a Boston hospital for observation. Neurological examination was positive, and the diagnosis of post-vaccinal encephalomyelitis made. This illness left the child with severe and permanent damage, paralysis of the left arm and leg, and it was felt that the boy would never walk or talk again. Within the next year Carl did learn to walk and talk again, although his speech was quite unintelligible.

A year after his illness, Carl was again entered in kindergarten, where the teacher found him was ill, and to handle as the older was so large that she was unable to give him the individual attention he needed and deserved so much, and Carl was disturbing to the rest of the class. Subsequent to this, the parents initiated discussion of placement with the child workers. They had concluded that they were being unfair to Carl and to explore other possibilities for helping him. They admitted complete inability to cope with his erratic and hyperactive behavior.

In making plans with the parents for Carl's care, the

months. Two of the children were referred for placement because of the mother's inability to supervise their conduct because of rheumatic fever due to her own ill health. A third child was referred because of hyperactivity which his deaf mute parents were unable to supervise and control. The fourth, a child with multiple handicaps, was referred for placement because of her mother's terminal illness and inability to give adequate care to the child. In all of these cases, there was extensive planning and preparation for the placement by both the referring worker and the child-placing worker.

Case No. 1 - Carl

Placement was requested for Carl, aged six, by the Social Work Supervisor in the Southeastern District of the Public Health Department, who had known this boy through one of the orthopedic clinics. The diagnosis was post-vaccinal encephalomyelitis with left hemiplegia. Placement was requested because of the mother's thyroid condition and deaf-muteness in both parents, making it difficult for them to supervise and control Carl's extreme hyperactivity and erratic behavior.

The family consisted of both deaf-mute parents in their early thirties, and an older sister of eight who was also a deaf-mute and resided during the school year at a state school for the deaf. The parents were described as intelligent and industrious, and extremely devoted to both handicapped children. There was a close relationship with the normal-speaking maternal grandparents who were fond of Carl, but unable to take him because of their own ill health.

Before his serious illness, Carl had been a normal boy, except for delayed speech. It was the vaccination to public school kindergarten when Carl was four that precipitated the encephalomyelitis. Within ten days of the vaccination, he complained of not feeling well, vomited, had convulsions on the left side, and went into a coma with a temperature of 107° which lasted several days. Carl was admitted to a local hospital and then transferred to a Boston hospital for observation. Neurological consultation was sought, and the diagnosis of post-vaccinal encephalomyelitis made. This illness left the child with severe scattered brain damage, paralysis of the left arm and leg, and it was felt that the boy would never walk or talk again. Within the next year Carl did learn to walk and talk again, although his speech was quite unintelligible.

A year after his illness, Carl was again entered in kindergarten, where the teacher found him too difficult to handle as the class was so large that she was unable to give him the individual attention he needed and demanded so much, and Carl was disturbing to the rest of the class. Subsequent to this, the parents initiated discussion of placement with the clinic worker. They had concluded that they were being unfair to Carl not to explore other possibilities for helping him. They admitted complete inability to cope with his erratic and hyperactive behavior.

In making plans with the parents for Carl's care, the

Case No. 1 - Carl

Placement was requested for Carl, aged six, by the Social Work Supervisor in the Southeastern District of the Public Health Department, who had known this boy through one of the orthopedic clinics. The diagnosis was post-vaccinal encephalomyelitis with left hemiplegia. Placement was requested because of the mother's thyroid condition and deaf-muteness in both parents, making it difficult for them to supervise and control Carl's extreme hyperactivity and erratic behavior.

The family consisted of both deaf-mute parents in their early thirties, and an older sister of eight who was also a deaf-mute and resided during the school year at a state school for the deaf. The parents were described as intelligent and industrious, and extremely devoted to both handicapped children. There was a close relationship with the normal-speaking maternal grandparents who were fond of Carl, but unable to take him because of their own ill health.

Before his serious illness, Carl had been a normal boy, except for delayed speech. It was the vaccination to public school kindergarten when Carl was four that precipitated the encephalomyelitis. Within ten days of the vaccination, he complained of not feeling well, vomited, had convulsions on the left side, and went into a coma with a temperature of 107° which lasted several days. Carl was admitted to a local hospital and then transferred to a Boston hospital for observation. Neurological consultation was sought, and the diagnosis of post-vaccinal encephalomyelitis made. This illness left the child with severe scattered brain damage, paralysis of the left arm and leg, and it was felt that the boy would never walk or talk again. Within the next year Carl did learn to walk and talk again, although his speech was quite unintelligible.

A year after his illness, Carl was again entered in kindergarten, where the teacher found him too difficult to handle as the class was so large that she was unable to give him the individual attention he needed and demanded so much, and Carl was disturbing to the rest of the class. Subsequent to this, the parents initiated discussion of placement with the clinic worker. They had concluded that they were being unfair to Carl not to explore other possibilities for helping him. They admitted complete inability to cope with his erratic and hyperactive behavior.

In making plans with the parents for Carl's care, the

Social Work Supervisor attempted to interest a hospital school in taking Carl, but after the psychologist at that school found it impossible to test Carl because of his hyperactivity, it was their opinion that at that point admission to their school was out of the question. Admission was again made to the Boston hospital where Carl had been sent for observation during his illness, in order to evaluate whether his difficult behavior was related to the fact that his home was not a normal one, and one in which any child might take advantage of his parents' handicap or whether his behavior might directly be attributed to brain damage. From observation in their playroom, and by the psychiatrist, the hospital reported that Carl was functioning intellectually and socially on the level of a two year old, but that he showed some learning ability and that in the right environment, he might develop to a higher level and his hyperactivity decrease.

The Social Work Supervisor made application in person to Children's Mission for Carl's placement in a foster home. In making her referral, she gave detailed information on the orthopedic clinic's contact with the patient and his family, a medical history of the illness and reports of contacts with the Boston hospital as well as a social summary. In this conference, the goal of placement was decided as that of helping Carl develop to the limits of his ability, and of casework help with the parents relative to his eventual return home. It was decided that casework responsibility would lie with Children's Mission, and that responsibility for medical care would remain with Services for Crippled Children. It was also suggested at this meeting that the Children's Mission worker might make the initial visit to see the parents and Carl with the Public Health Social Work Supervisor.

The Children's Mission worker went with the Public Health Social Work Supervisor in the initial visit to see the maternal grandmother, who would act as interpreter between the parents and workers. During this interview, the public health worker took an active part in describing to the grandmother the appropriate function of each agency and where casework responsibility would lie once placement was made. She asked the grandmother to describe Carl's general habits and abilities to the Children's Mission worker, who then took over the interview. The grandmother explained objectively and with intelligence that Carl gets away with a good deal because his mother could not hear, so that he had been unable to improve his behavior in his own home. A visit was made then to see the parents and Carl with the grandmother as interpreter. The grandmother interpreted

Social Work Supervisor attempted to interest a hospital school in taking Carl, but after the psychologist at that school found it impossible to test Carl because of his hyperactivity, it was their opinion that at that point admission to their school was out of the question. Admission was again made to the Boston hospital where Carl had been sent for observation during his illness, in order to evaluate whether his difficult behavior was related to the fact that his home was not a normal one, and one in which any child might take advantage of his parents' handicap or whether his behavior might directly be attributed to brain damage. From observation in their playroom, and by the psychiatrist, the hospital reported that Carl was functioning intellectually and socially on the level of a two year old, but that he showed some learning ability and that in the right environment, he might develop to a higher level and his hyperactivity decrease.

The Social Work Supervisor made application in person to Children's Mission for Carl's placement in a foster home. In making her referral, she gave detailed information on the orthopedic clinic's contact with the patient and his family, a medical history of the illness and reports of contacts with the Boston hospital as well as a social summary. In this conference, the goal of placement was decided as that of helping Carl develop to the limits of his ability, and of casework help with the parents relative to his eventual return home. It was decided that casework responsibility would lie with Children's Mission, and that responsibility for medical care would remain with Services for Crippled Children. It was also suggested at this meeting that the Children's Mission worker might make the initial visit to see the parents and Carl with the Public Health Social Work Supervisor.

The Children's Mission worker went with the Public Health Social Work Supervisor in the initial visit to see the maternal grandmother, who would act as interpreter between the parents and workers. During this interview, the public health worker took an active part in describing to the grandmother the appropriate function of each agency and where casework responsibility would lie once placement was made. She asked the grandmother to describe Carl's general habits and abilities to the Children's Mission worker, who then took over the interview. The grandmother explained objectively and with intelligence that Carl gets away with a good deal because his mother could not hear, so that he had been unable to improve his behavior in his own home. A visit was made then to see the parents and Carl with the grandmother as interpreter. The grandmother interested

to the mother the child-placing agency and its policy of carefully selecting a foster home to meet the needs of the individual child. She explained the purpose of the placement as an attempt to train and discipline Carl so that he would then be able to live in his own home. Worker asked the grandmother to stress with the mother the fact that the agency had not yet located a foster home and that it might take some time. Plans were made for the parents to prepare Carl for the placement by explaining that he would be going away like his older sister, but would be visiting home frequently.

It did take some time to obtain a foster home for this child, and it was not until two months later that he was placed. The foster parents were ones who had answered a general advertisement in the paper. The foster family consisted of three other children a good deal older than Carl, and there was an atmosphere of warmth and relaxation in the home. The child-placing worker felt that the foster mother had the qualities of flexibility and initiative that Carl would need. The worker described to the foster mother the boy's illness and the problems it had presented in the family, and with which the handicapped parents had been unable to cope. She reassured the foster family that the agency would be working closely together with them to help Carl. This foster home was discussed with the Public Health Social Work Supervisor, since she had known Carl and his family, and it was approved by her.

The family accepted the plan of placement of Carl in this home and plans were made for him to visit his own home every other weekend. The placement was carried out with the mother and grandmother accompanying the social worker.

Carl has been in this foster home for nine months, and has continued to visit his own home every other weekend. At first, the foster mother saw some regressive tendencies as a reaction to Carl's weekend visits home, but after the initial phase of placement, there were no further evidences of regression. There has been over-all improvement of his hyperactivity and his speech, to the point where he has a longer attention span, and where he can put sentences together and can be understood better. Since placement, there have been no evidences of separation anxiety and he has accepted the foster home and has been accepted by them. Medically, he continues to be followed by Services for Crippled Children, and very soon will have another evaluation done at the Boston hospital to determine how much progress has actually been made in the foster home, and what might

to the mother the child-placing agency and its policy of carefully selecting a foster home to meet the needs of the individual child. She explained the purpose of the placement as an attempt to train and discipline Carl so that he would then be able to live in his own home. Worker asked the grandmother to stress with the mother the fact that the agency had not yet located a foster home and that it might take some time. Plans were made for the parents to prepare Carl for the placement by explaining that he would be going away like his older sister, but would be visiting home frequently.

It did take some time to obtain a foster home for this child, and it was not until two months later that he was placed. The foster parents were ones who had answered a general advertisement in the paper. The foster family consisted of three other children a good deal older than Carl, and there was an atmosphere of warmth and relaxation in the home. The child-placing worker felt that the foster mother had the qualities of flexibility and initiative that Carl would need. The worker described to the foster mother the boy's illness and the problems it had presented in the family, and with which the handicapped parents had been unable to cope. She reassured the foster family that the agency would be working closely together with them to help Carl. This foster home was discussed with the Public Health Social Work Supervisor, since she had known Carl and his family, and it was approved by her.

The family accepted the plan of placement of Carl in this home and plans were made for him to visit his own home every other weekend. The placement was carried out with the mother and grandmother accompanying the social worker.

Carl has been in this foster home for nine months, and has continued to visit his own home every other weekend. At first, the foster mother saw some regressive tendencies as a reaction to Carl's weekend visits home, but after the initial phase of placement, there were no further evidences of regression. There has been over-all improvement of his hyperactivity and his speech, to the point where he has a longer attention span, and where he can put sentences together and can be understood better. Since placement, there have been no evidences of separation anxiety and he has accepted the foster home and has been accepted by them. Medically, he continues to be followed by services for Crippled Children, and very soon will have another evaluation done at the Boston Hospital to determine how much progress has actually been made in the foster home, and what might

be expected in the future.

DISCUSSION

This boy, whose prognosis was questionable and who presented too much of a problem for his deaf-mute parents to cope with, has made in the foster home, steady progress in regard to the problems that he presented to his parents at the time placement was requested. His hyperactivity, which was difficult for his own parents to control because of their own handicap, has decreased and his speech has improved in an environment with normal speaking people. At no time during placement has he exhibited any separation anxiety, and has visited home on a regular basis every other weekend.

This boy, his parents, and the foster mother, were prepared extensively before the actual placement was made. There was adequate data presented to the child-placing agency on which they might select a foster home and work with the family and child before and during placement. There was extensive joint planning on the part of the referring worker and the child-placing worker, careful selection of the foster home to satisfy this child's medical and emotional needs, and detailed information on this boy's behaviour and medical problems given to the foster mother to help her work with Carl. There was active participation by the parents and maternal grandmother in planning for the care of Carl, and

be expected in the future.

DISCUSSION

This boy, whose prognosis was questionable and who presented too much of a problem for his deaf-mute parents to cope with, has made in the foster home, steady progress in regard to the problems that he presented to his parents at the time placement was requested. His hyperactivity, which was difficult for his own parents to control because of their own handicap, has decreased and his speech has improved in an environment with normal speaking people. At no time during placement has he exhibited any separation anxiety, and has visited home on a regular basis every other weekend.

This boy, his parents, and the foster mother, were prepared extensively before the actual placement was made. There was adequate data presented to the child-placing agency on which they might select a foster home and work with the family and child before and during placement. There was extensive joint planning on the part of the referring worker and the child-placing worker, careful selection of the foster home to satisfy this child's medical and emotional needs, and detailed information on this boy's behaviour and medical problems given to the foster mother to help her work with Carl. There was active participation by the parents and maternal grandmother in planning for the care of Carl, and

full understanding and acceptance of the need for placement.

An explanation of the reason for placement was given to the child by his parents in terms he would understand. There would seem to be a definite relationship between the adequacy of planning and preparation for this child's care and the successful adjustment that he made in the foster home.

Lois had been in hospitals all but two weeks of her life. At birth, she weighed two pounds, ten ounces, and was in the hospital for eight months until her parents took her home against medical advice. However, they found care of the child, particularly feeding, difficult; the baby became malnourished, and after two weeks had to be admitted to another hospital, where she was also to have plastic surgery done on the cleft palate under the plastic program of Services for Crippled Children. At the time referral to Children's Mission was made, the baby was still too weak to have the operation performed.

Her family consisted of both parents who had been married previously and were children by the previous marriage were under the custody of the other spouse. Lois was the only child by this marriage. Both parents were described as alcoholic, of low intelligence, irresponsible and of poor reputation. The mother had cirrhosis of the liver and was not expected to live long. She had been hospitalized several times with delirium tremens and there was little hope that the mother would or could ever take the child. When Lois was ready for discharge from the hospital four months earlier, the Public Health Social Work Supervisor in the District Office had requested placement through a local child-placing agency. The parents at first had agreed to placement, but became at the last minute they had changed their minds about placement and wanted the child home, the child-placing agency petitioned the Probate Court for temporary guardianship of Lois. Plans for placement were made three times by the child-placing agency, but each time the baby's precarious condition prevented discharge from the hospital. After further study of the medical history, the agency felt that the baby was not suitable material for ordinary foster home placement, and recommended care in a convalescent home or a highly specialized foster home such as one Children's Mission might have. This decision was based on the need for specialized care of the child's feeding difficulties and the lack of facilities in the local agency to meet this need.

full understanding and acceptance of the need for placement. An explanation of the reason for placement was given to the child by his parents in terms he would understand. There would seem to be a definite relationship between the adequacy of planning and preparation for this child's care and the successful adjustment that he made in the foster home.

Case No. 2 - Lois

The Social Work Supervisor of the South Central District, Massachusetts Department of Public Health, requested a medical foster home placement of six or eight months' duration for Lois, a child with multiple handicaps, in preparation for surgery for repair of her cleft palate. Lois had been a premature baby, born with a cleft palate and congenital dislocation of the hips, and there was a question of Mongolism.

Lois had been in hospitals all but two weeks of her life. At birth, she weighed two pounds, ten ounces, and was in the hospital for eight months until her parents took her home against medical advice. However, they found care of the child, particularly feeding, difficult; the baby became malnourished, and after two weeks had to be admitted to another hospital, where she was also to have plastic surgery done on the cleft palate under the plastic program of Services for Crippled Children. At the time referral to Children's Mission was made, the baby was still too weak to have the operation performed.

Her family consisted of both parents who had been married previously and whose children by the previous marriage were under the custody of the other spouse. Lois was the only child by this marriage. Both parents were described as alcoholic, of low intelligence, irresponsible and of poor reputation. The mother had cirrhosis of the liver and was not expected to live long. She had been hospitalized several times with delirium tremens and there was little hope that the mother would or could ever take the child. When Lois was ready for discharge from the hospital four months earlier, the Public Health Social Work Supervisor in the District Office had requested placement through a local child-placing agency. The parents at first had agreed to placement, but because at the last minute they had changed their minds about placement and wanted the child home, the child-placing agency petitioned the Probate Court for temporary guardianship of Lois. Plans for placement were made three times by the child-placing agency, but each time the baby's precarious condition prevented discharge from the hospital. After further study of the medical history, the agency felt that the baby was not suitable material for ordinary foster home placement, and recommended care in a convalescent home or a highly specialized foster home such as one Children's Mission might have. This decision was based on the need for specialized care of the child's feeding difficulties and the lack of facilities in the local agency to meet this need.

It was the Public Health Social Work Supervisor in the District office who referred this case to Children's Mission for care. Included in the data were the reason for referral, a medical history from the hospitals, a social summary on the family, and their contacts with the local child-placing agency.

The Children's Mission selected for Lois a foster home in which the foster mother was a trained nurse, and was especially good with babies. Both the social worker and foster mother visited Lois in the hospital, where they obtained the formula and observed Lois being fed through a syringe.

Before placement, there was close contact between all of the agencies involved in this case in order to plan for Lois' placement. The local child-placing agency who had guardianship of the child gave permission for placement, and since casework responsibility was to be carried by this agency rather than either Crippled Children's Services or Children's Mission, the parents were seen by that agency in order to discuss the placement plans with them. When placement with Children's Mission was discussed with the parents, they were fully accepting of placement of Lois since they now realized their own inadequacy in meeting her special needs. Although the father was willing to pay for Lois' board, he was unable to, because of low income. Crippled Children's Services agreed to finance the cost of Lois' care.

Lois was placed by Children's Mission for a period of twenty-eight months. After four months in the first foster home, the child had to be replaced because the foster mother planned to give up the care of foster children. Another home was found in which the foster mother had a simple, practical approach to the care of children. In her late forties, the foster mother had four children of her own, all over sixteen years of age, the eldest a nurse who was able to advise the foster mother on nursing care. Before placement of Lois, the Children's Mission worker prepared the foster mother for the eventual possibility of becoming too attached to a foster child who would be only under temporary care. While in placement, Lois improved tremendously under the loving care and attention of the whole family, who became devoted to the child. The natural mother visited Lois only once because of her own frequent hospitalizations, but the Children's Mission worker did contact the family periodically on the child's progress. Both Children's Mission and Crippled Children's Services finally decided that because of

43

It was the Public Health Social Work Supervisor in the District Office who referred this case to Children's Mission for care. Included in the data were the reason for referral, a medical history from the hospital, a social summary on the family, and their contacts with the local child-placing agency.

The Children's Mission selected for Lois a foster home in which the foster mother was a trained nurse, and was especially good with babies. Both the social worker and foster mother visited Lois in the hospital, where they obtained the formula and observed Lois being fed through a syringe.

Before placement, there was close contact between all of the agencies involved in this case in order to plan for Lois' placement. The local child-placing agency who had guardianship of the child gave permission for placement, and since casework responsibility was to be carried by this agency rather than either Crippled Children's Services or Children's Mission, the parents were seen by that agency in order to discuss the placement plans with them. When placement with Children's Mission was discussed with the parents, they were fully accepting of placement of Lois since they now realized their own inadequacy in meeting her special needs. Although the father was willing to pay for Lois' board, he was unable to, because of low income. Crippled Children's Services agreed to finance the cost of Lois' care.

Lois was placed by Children's Mission for a period of twenty-eight months. After four months in the first foster home, the child had to be replaced because the foster mother planned to give up the care of foster children. Another home was found in which the foster mother had a simple, practical approach to the care of children. In her late forties, the foster mother had four children of her own, all over sixteen years of age, the eldest a nurse who was able to advise the foster mother on nursing care. Before placement of Lois, the Children's Mission worker prepared the foster mother for the eventual possibility of becoming too attached to a foster child who would be only under temporary care. While in placement, Lois improved tremendously under the loving care and attention of the whole family, who became devoted to the child. The natural mother visited Lois only once because of her own frequent hospitalizations, but the Children's Mission worker did contact the family periodically on the child's progress. Both Children's Mission and Crippled Children's Services finally decided that because of

the natural's mother's terminal illness and the father's alcoholism, and the plastic surgeon's decision to postpone plastic repair of the cleft palate indefinitely, the child would probably never be able to return to her own home, and that the agencies could not assume custodial care of this child. Lois was given a psychometric test and found to be of low mentality, and application was made for Wrentham. At no time could the foster mother accept the child's mental limitations, and she was very much upset when the application was accepted. At the time that Lois left the care of Children's Mission, she was still very much of a miniature child, was able to walk alone despite her dislocated hips, but did not have the mentality or physical ability to talk. In contact with, this child would probably not have made as much progress in any other home.

Although this was a protective case, in the sense that guardianship was in the hands of the local child-placing agency, and the child would probably never return to its parents, the parents were included to a limited extent in the planning for this child, and after placement, periodic letters were sent to the mother informing her of progress that Lois was making. The parents were encouraged to visit Lois during placement, but due to the mother's severe terminal illness and the father's alcoholism and disinterest, they made only one visit during Lois' stay in the foster home. Lois, of course, was too young and was ill for much pre-placement preparation. However, the success of this placement seems to lie with the extensive inter-agency pre-placement planning and the careful selection of foster home to meet this child's physical and emotional needs.

DISCUSSION

This multiply handicapped child made tremendous strides in both foster homes, particularly the latter where she received devoted care and attention from all members of the family. Despite the foster mother's extreme over-attachment to this child, which was difficult for the agencies involved to contend with, this child would probably not have made as much progress in any other home.

Although this was a protective case, in the sense that guardianship was in the hands of the local child-placing agency, and the child would probably never return to its parents, the parents were included to a limited extent in the planning for this child, and after placement, periodic letters were sent to the mother informing her of progress that Lois was making. The parents were encouraged to visit Lois during placement, but due to the mother's severe terminal illness and the father's alcoholism and disinterest, they made only one visit during Lois' stay in the foster homes. Lois, of course, was too young and too ill for much pre-placement preparation. However, the success of this placement seems to lie with the extensive inter-agency pre-placement planning and the careful selection of foster homes to meet this child's physical and emotional needs.

DISCUSSION

This multiply handicapped child made tremendous strides in both foster homes, particularly the latter where she received devoted care and attention from all members of the family. Despite the foster mother's extreme over-attachment to this child, which was difficult for the agencies involved to contend with, this child would probably not have made as much progress in any other home.

Although this was a protective case, in the sense that guardianship was in the hands of the local child-placing agency, and the child would probably never return to its parents, the parents were included to a limited extent in the planning for this child, and after placement, periodic letters were sent to the mother informing her of progress that Lois was making. The parents were encouraged to visit Lois during placement, but due to the mother's severe terminal illness and the father's alcoholism and disinterest, they made only one visit during Lois' stay in the foster homes. Lois, of course, was too young and too ill for much pre-placement preparation. However, the success of this placement seems to lie with the extensive inter-agency pre-placement planning and the careful selection of foster homes to meet this child's physical and emotional needs.

Case No. 3 - Dolly

Dolly, a bright attractive four year old, was referred by the Social Work Supervisor at the North Reading Rheumatic Fever Clinic for temporary placement until Dolly's mother might recover sufficiently from a nervous breakdown to regain ability to care for her family.

Dolly's mother's breakdown had been precipitated at the onset of Dolly's illness, four month's earlier. Dolly's sister, Sara (case No. 4), for whom placement was requested at the same time, had been sick in bed with rheumatic fever for a year, and the mother was fearful that both children might be faced with a long seige of illness and serious heart damage. It was also felt marital strain between the parents contributed to the mother's breakdown. The father, who was employed as a bus driver, earning a modest income, had the major burden of the care of the six children and the home during the mother's illness, and, in order to escape financial worries and the burden of caring for the children, was drinking a good deal. Although Dolly's medical history was inconclusive for rheumatic heart disease, she had had symptoms that were characteristic of mild rheumatic fever and would need close supervision on a regulated program of increasing physical activity. Because Dolly was an active child who had been spoiled by family and neighbors because of her winning manner, it had been difficult for the family to give her the medical supervision that she needed, and with the mother's illness and anxiety about the children's illness it was even more difficult to give care to the ill children.

The Social Work Supervisor in the clinic called a conference with the Catholic Charitable Bureau worker and the local public health nurse who had both known the family, in order to discuss the problem of medical care for the two sisters. Through joint discussion, it was decided that this family, who had a warm relationship and interest in their children, would be able under normal circumstances to provide the necessary care that the children would need, but during the time when the mother was recovering from her breakdown, it was impossible for her to manage, and, in the interest of her own health and that of the two children, it would be advisable to make plans for temporary placement in a convalescent facility. It was decided that Children's Mission might best be able to meet the children's medical and social needs during this period. It was felt that the parents would accept the plan of placement on the basis of their present situation, but that the children might be considerably

Case No. 3 - Dolly

Dolly, a bright attractive four year old, was referred by the Social Work Supervisor at the North Reading Rheumatic Fever Clinic for temporary placement until Dolly's mother might recover sufficiently from a nervous breakdown to regain ability to care for her family.

Dolly's mother's breakdown had been precipitated at the onset of Dolly's illness, four months earlier. Dolly's sister, Sara (case No. 4), for whom placement was requested at the same time, had been sick in bed with rheumatic fever for a year, and the mother was fearful that both children might be faced with a long siege of illness and serious heart damage. It was also felt that strain between the parents contributed to the mother's breakdown. The father, who was employed as a bus driver, earning a modest income, had the major burden of the care of the six children and the home during the mother's illness, and, in order to escape financial worries and the burden of caring for the children, was drinking a good deal. Although Dolly's medical history was inconclusive for rheumatic heart disease, she had had symptoms that were characteristic of mild rheumatic fever and would need close supervision on a regulated program of increasing physical activity. Because Dolly was an active child who had been spoiled by family and neighbors because of her winning manner, it had been difficult for the family to give her the medical supervision that she needed, and with the mother's illness and anxiety about the children's illness it was even more difficult to give care to the ill children.

The Social Work Supervisor in the clinic called a conference with the Catholic Charitable Bureau worker and the local public health nurse who had been working with the family, in order to discuss the problem of medical care for the two sisters. Through joint discussion, it was decided that this family, who had a warm relationship and interest in their children, would be able under normal circumstances to provide the necessary care that the children would need, but during the time when the mother was recovering from her breakdown, it was impossible for her to manage, and, in the interest of her own health and that of the two children, it would be advisable to make plans for temporary placement in a convalescent facility. It was decided that Children's Mission might best be able to meet the children's medical and social needs during this period. It was felt that the parents would accept the plan of placement on the basis of their present situation, but that the children might be considerably

upset at the prospect of leaving their home, so that it might be more difficult to secure their approval.

On the next clinic visit, the doctor in the presence of the Social Work Supervisor recommended placement of Dolly and Sara in a Children's Mission convalescent home. It was difficult for the parents to ask for help in their present situation, but on the basis of the health needs of the children and the mother, the parents were able to accept the idea of placement, requesting that the children be placed together.

A letter of referral was sent to Children's Mission asking for placement of the two children for six weeks, until their mother would again be able to care for them. Medical information on the two children was given, as well as specific medical recommendations in regard to physical limitations and medication, and social data on the family and the two children. In pre-placement conferences between the two agencies, it was decided that the Catholic Charitable Bureau worker would continue to offer intensive casework services to the mother around the problem of her breakdown; the Children's Mission worker would work with the mother only in terms of medical interpretation and the placement of the children; and that the Children's Mission worker would keep in contact with the public health social worker as to the placement progress.

In selecting a foster home for the sisters, it was decided that they would be placed in a group home, where they could be placed together and where all of the children were on regulated physical activity. This type of placement was also chosen because the family had shown some resistance to the idea of individual foster home placement. The foster mother was given medical information that would be of help to her during the placement period. It was explained to her that Dolly and Sara were being placed temporarily because of the mother's nervous breakdown and inability to care for the sisters. Dolly's and Sara's personalities and habits were described and the foster mother was told that both sisters would probably be homesick during the initial period of placement.

The Children's Mission worker had an interview with the parents and children in order to interpret to them in more detail the function of Children's Mission, and what the typical convalescent group home was like. The whole family were present during the interview, and all members, particularly the children, asked questions about the placement. The worker told the children approximately how long the placement would last, and that they would be in isolation the first forty-eight hours of placement. Since the Children's

upset at the prospect of leaving their home, so that it might be more difficult to secure their approval.

On the next clinic visit, the doctor in the presence of the Social Work Supervisor recommended placement of Dolly and Sara in a Children's Mission convalescent home. It was difficult for the parents to ask for help in their present situation, but on the basis of the health needs of the children and the mother, the parents were able to accept the idea of placement, requesting that the children be placed together.

A letter of referral was sent to Children's Mission asking for placement of the two children for six weeks, until their mother would again be able to care for them. Medical information on the two children was given, as well as specific medical recommendations in regard to physical limitations and medication, and social data on the family and the two children. In pre-placement conferences between the two agencies, it was decided that the Catholic Charitable Bureau worker would continue to offer intensive casework services to the mother around the problem of her breakdown; the Children's Mission worker would work with the mother only in terms of medical interpretation and the placement of the children; and that the Children's Mission worker would keep in contact with the public health social worker as to the placement progress.

In selecting a foster home for the sisters, it was decided that they would be placed in a group home, where they could be placed together and where all of the children were on regulated physical activity. This type of placement was also chosen because the family had shown some resistance to the idea of individual foster home placement. The foster mother was given medical information that would be of help to her during the placement period. It was explained to her that Dolly and Sara were being placed temporarily because of the mother's nervous breakdown and inability to care for the sisters. Dolly's and Sara's personalities and habits were described and the foster mother was told that both sisters would probably be homesick during the initial period of placement.

The Children's Mission worker had an interview with the parents and children in order to interpret to them in more detail the function of Children's Mission, and what the typical convalescent group home was like. The whole family were present during the interview, and all members, particularly the children, asked questions about the placement. The worker told the children approximately how long the placement would last, and that they would be in isolation the first forty-eight hours of placement. Since the Children's

Mission worker knew from information that the referring worker had said that Dolly was fearful when the clinic laboratory technician had attempted to draw blood, she prepared Dolly for the fact that a doctor would visit monthly in order to take cultures and sedimentation rates. The worker had the impression that the children were very attached to their mother and constantly sought her love and attention.

Several days later, the placement was made. The mother who was extremely upset to see the children go, was unable to accompany them on the placement. Although Dolly did not say much enroute to the foster home, the worker knew that both girls needed a good deal of reassurance and she continued to interpret to them that placement was temporary only until their mother was well again. During placement, Dolly generally adjusted well, although she was a feeding problem in the beginning, and continued to be fearful of the needle. A few days after they were placed, both girls attempted to leave the home to find a policeman who would take them to their own home, but after this they adjusted and openly admitted that they liked the convalescent home. Both parents visited frequently, and gradually the mother gained enough strength so that she was able to take the girls home after the prescribed length of time.

Case No. 4 - Sara

Sara, aged nine, like her sister, Dolly (see case No. 3), was referred to Children's Mission by the social worker at the North Reading Rheumatic Fever Clinic for six weeks' placement until her mother might sufficiently recover from a nervous breakdown brought on by Dolly's illness, to give the girls the care that they needed.

Sara had had two hospitalizations previous to the present illness, one when she was four, for poliomyelitis, and another at eight, for scarlet fever. At the time of placement, she had been in bed a year with questionable rheumatic fever. The illness began with severe fainting spells and complaints of pericardial pain. On examination at the Rheumatic Fever Clinic, her heart was found to be of normal size with regular rhythm. There was no residual heart damage, and her prognosis was considered to be good. Sara was apprehensive about her health, however; she was fearful of the clinic and hospitalizations in general.

The referring worker felt that Sara, of the two girls, would probably be more upset by placement because of her

Mission worker knew from information that the referring worker had said that Dolly was fearful when the clinic laboratory technician had attempted to draw blood, she prepared Dolly for the fact that a doctor would visit monthly in order to take cultures and sedimentation rates. The worker had the impression that the children were very attached to their mother and constantly sought her love and attention.

Several days later, the placement was made. The mother who was extremely upset to see the children go, was unable to accompany them on the placement. Although Dolly did not say much enroute to the foster home, the worker knew that both girls needed a good deal of reassurance and she continued to interpret to them that placement was temporary only until their mother was well again. During placement, Dolly generally adjusted well, although she was a leading problem in the beginning, and continued to be fearful of the needle. A few days after they were placed, both girls attempted to leave the home to find a policeman who would take them to their own home, but after this they adjusted and openly admitted that they liked the convalescent home. Both parents visited frequently, and gradually the mother gained enough strength so that she was able to take the girls home after the prescribed length of time.

Case No. 4 - Sara

Sara, aged nine, like her sister, Dolly (see case No. 3), was referred to Children's Mission by the social worker at the North Reading Rheumatic Fever Clinic for six weeks' placement until her mother might sufficiently recover from a nervous breakdown brought on by Dolly's illness, to give the girls the care that they needed.

Sara had had two hospitalizations previous to the present illness, one when she was four, for poliomyelitis, and another at eight, for scarlet fever. At the time of placement, she had been in bed a year with questionable rheumatic fever. The illness began with severe fainting spells and complaints of pericardial pain. On examination at the Rheumatic Fever Clinic, her heart was found to be of normal size with regular rhythm. There was no residual heart damage, and her prognosis was considered to be good. Sara was apprehensive about her health, however; she was fearful of the clinic and hospitalizations in general.

The referring worker felt that Sara, of the two girls, would probably be more upset by placement because of her

DISCUSSION OF CASE NO. 3 AND CASE NO. 4

The adjustment of these two sisters to placement was successful, beyond what seemed to be evidences of separation anxiety in the initial phase of placement. Both girls attempted to go home a few days after the placement was made, and during the first few weeks at the foster home both seemed to need constant reassurance that placement was for only a temporary period. However, as they became more contented in the foster home, they no longer needed this reassurance.

Preparation of the parents for the referral by the clinic social worker was successful, for the parents were able to understand the reason and accept the need for referral. Adequate data was sent by the clinic social worker to the child-placing worker, which helped her considerably in working with the family and children on pre-placement planning and preparation. Both the parents and the children participated actively in the interview held by the child-placing worker with the family, to plan for placement. The children were told frankly the reason for placement; the placement process and the foster home were described to them. A group home was selected to satisfy the medical and emotional needs of the children, and one that would not be threatening to the parents, who did have some resistance to individual foster home placement. The

DISCUSSION OF CASE NO. 3 AND CASE NO. 4

The adjustment of these two sisters to placement was successful, beyond what seemed to be evidences of separation anxiety in the initial phase of placement. Both girls attempted to go home a few days after the placement was made, and during the first few weeks at the foster home both seemed to need constant reassurance that placement was for only a temporary period. However, as they became more contented in the foster home, they no longer needed this reassurance.

Preparation of the parents for the referral by the clinic social worker was successful, for the parents were able to understand the reason and accept the need for referral. Adequate data was sent by the clinic social worker to the child-placing worker, which helped her considerably in working with the family and children on pre-placement planning and preparation. Both the parents and the children participated actively in the interview held by the child-placing worker with the family, to plan for placement. The children were told frankly the reason for placement; the placement process and the foster home were described to them. A group home was selected to satisfy the medical and emotional needs of the children, and one that would not be threatening to the parents, who did have some resistance to individual foster home placement. The

parents accepted the need for continued contact with their children during placement, and visited frequently. There was, in all probability, a definite relationship between the successful adjustment of the two sisters to placement, and the adequacy of preparation of them, the parents and the foster home.

The following four cases adjusted moderately successfully to placement. A moderately successful adjustment is defined as one in which there was over-all progress in terms of the original reason for placement, but in which there were some extreme symptoms of anxiety or behavior disturbances exhibited throughout placement.

All four of these children were girls, ranging from five to nine years of age. Two of the girls, with rheumatic fever, were referred for convalescent care due to poor physical factors in their own homes. The third, a poliomyelitis patient, was referred for a year's placement because of overcrowding in her own home and her mother's inability to cope with her physical needs. The fourth, a rheumatic fever patient, was referred because emotional tension in her home seemed to be impeding her medical progress. From the criteria developed for adequacy of preparation, it is evident that in all of these cases there was inadequate preparation in one or more areas, and that there was a relationship between inadequate preparation and only moderately successful adjustment of each of the cases to foster home placement.

In the first two cases, there was inadequate preparation

parents accepted the need for continued contact with their children during placement, and visited frequently. There was, in all probability, a definite relationship between the successful adjustment of the two sisters to placement, and the adequacy of preparation of them, the parents and the foster home.

CHAPTER VI

FOUR CASES OF CHILDREN WHOSE ADJUSTMENT TO PLACEMENT
WAS MODERATELY SUCCESSFUL

The following four cases adjusted moderately successfully to placement. A moderately successful adjustment is defined as one in which there was over-all progress in terms of the original reason for placement, but in which there were some extreme symptoms of anxiety or behavior disturbances exhibited throughout placement.

All four of these children were girls, ranging from five to nine years of age. Two of the girls, with rheumatic fever, were referred for convalescent care due to poor physical factors in their own homes. The third, a poliomyelitis patient, was referred for a year's placement because of overcrowding in her own home and her mother's inability to cope with her physical needs. The fourth, a rheumatic fever patient, was referred because emotional tension in her home seemed to be impeding her medical progress. From the criteria developed for adequacy of preparation, it is evident that in all of these cases there was inadequate preparation in one or more areas, and that there was a relationship between inadequate preparation and only moderately successful adjustment of each of the cases to foster home placement.

In the first two cases, there was inadequate preparation

CHAPTER VI

FOUR CASES OF CHILDREN WHOSE ADJUSTMENT TO PLACEMENT WAS MODERATELY SUCCESSFUL

The following four cases adjusted moderately successfully to placement. A moderately successful adjustment is defined as one in which there was over-all progress in terms of the original reason for placement, but in which there were some extreme symptoms of anxiety or behavior disturbances exhibited throughout placement.

All four of these children were girls, ranging from five to nine years of age. Two of the girls, with rheumatic fever, were referred for convalescent care due to poor physical factors in their own homes. The third, a poliomyelitis patient, was referred for a year's placement because of overcrowding in her own home and her mother's inability to cope with her physical needs. The fourth, a rheumatic fever patient, was referred because emotional tension in her home seemed to be impeding her medical progress. From the criteria developed for adequacy of preparation, it is evident that in all of these cases there was inadequate preparation in one or more areas, and that there was a relationship between inadequate preparation and only moderately successful adjustment of each of the cases to foster home placement.

In the first two cases, there was inadequate preparation

by the referring worker of the family and the agency for the referral. In the third case, there was inadequate preparation of the parents and child for placement, and in the fourth case, there was inadequate preparation of the child.

Rose's family consisted of her parents and brother, a year older than Rose. Their apartment was on the top floor of a three tenement apartment house, and was poorly heated. The father, who was thirty-five years of age, was an irresponsible person who changed jobs frequently, and the mother claimed he never supported his family as well as he might have. There was a good deal of friction between the parents. The mother, aged thirty-two, was a nervous high-strung woman who was greatly concerned about Rose's illness and visited her frequently while she was hospitalized.

Marie was referred at the same time for convalescent placement. It was also thought that Marie was not well enough to return home, since she had a persistently elevated sedimentation rate, and the physical aspects of the home were not suitable for convalescence.

Marie's family consisted of her mother, aged forty-two, father, fifty-two, and five siblings besides Marie, ranging in age from twenty to thirteen. The home was overcrowded and poorly heated. Both parents and several of the older children were working, so that Marie would be unable to receive the close supervision that she needed during the convalescent period.

Since there seemed to be misunderstanding on the part of the Social Work Supervisor at the Sanatorium as to the pre-placement preparation and planning done by Children's Mission, an inter-agency conference was held. The sanatorium worker wondered why the child-placing worker would need to see the parents before placement was made, since she had already interpreted the function of the child-placing agency to the families. She had thought that the child-placing worker would write the parents notifying them of the transfer from the sanatorium to the foster home. The Children's Mission worker attempted to clarify the reasons for seeing parents before placement, explaining that she would be able to establish a relationship with the parents and be able to assume complete responsibility where the sanatorium social worker had left off. A social history on the girls was not

by the referring worker of the family and the agency for the referral. In the third case, there was inadequate preparation of the parents and child for placement, and in the fourth case, there was inadequate preparation of the child.

The following are the reasons for the inadequate preparation of the parents and child for placement:

1. The parents were not given adequate information about the child and the agency.

2. The parents were not given adequate information about the child's needs and the agency's services.

3. The parents were not given adequate information about the child's behavior and the agency's policies.

4. The parents were not given adequate information about the child's medical history and the agency's medical services.

5. The parents were not given adequate information about the child's educational needs and the agency's educational services.

6. The parents were not given adequate information about the child's social needs and the agency's social services.

7. The parents were not given adequate information about the child's financial needs and the agency's financial services.

8. The parents were not given adequate information about the child's legal needs and the agency's legal services.

9. The parents were not given adequate information about the child's religious needs and the agency's religious services.

10. The parents were not given adequate information about the child's cultural needs and the agency's cultural services.

11. The parents were not given adequate information about the child's ethnic needs and the agency's ethnic services.

12. The parents were not given adequate information about the child's sexual needs and the agency's sexual services.

13. The parents were not given adequate information about the child's gender needs and the agency's gender services.

14. The parents were not given adequate information about the child's identity needs and the agency's identity services.

15. The parents were not given adequate information about the child's self-esteem needs and the agency's self-esteem services.

16. The parents were not given adequate information about the child's self-respect needs and the agency's self-respect services.

17. The parents were not given adequate information about the child's self-worth needs and the agency's self-worth services.

18. The parents were not given adequate information about the child's self-confidence needs and the agency's self-confidence services.

19. The parents were not given adequate information about the child's self-reliance needs and the agency's self-reliance services.

20. The parents were not given adequate information about the child's self-control needs and the agency's self-control services.

21. The parents were not given adequate information about the child's self-discipline needs and the agency's self-discipline services.

22. The parents were not given adequate information about the child's self-motivation needs and the agency's self-motivation services.

23. The parents were not given adequate information about the child's self-direction needs and the agency's self-direction services.

24. The parents were not given adequate information about the child's self-actualization needs and the agency's self-actualization services.

25. The parents were not given adequate information about the child's self-fulfillment needs and the agency's self-fulfillment services.

26. The parents were not given adequate information about the child's self-achievement needs and the agency's self-achievement services.

27. The parents were not given adequate information about the child's self-fulfillment needs and the agency's self-fulfillment services.

28. The parents were not given adequate information about the child's self-achievement needs and the agency's self-achievement services.

29. The parents were not given adequate information about the child's self-fulfillment needs and the agency's self-fulfillment services.

30. The parents were not given adequate information about the child's self-achievement needs and the agency's self-achievement services.

Cases No. 5 and 6 - Rose and Marie

Rose, aged seven, and case number six, Marie, aged seven, were referred to Children's Mission by a doctor on the Rheumatic Fever Service, which was closing, at North Reading Sanatorium. Rose's home was not thought suitable to offer her convalescent care at this point in her illness.

Rose's family consisted of her parents and brother, a year older than Rose. Their apartment was on the top floor of a three tenement apartment house, and was poorly heated. The father, who was thirty-five years of age, was an irresponsible person who changed jobs frequently, and the mother claimed he never supported his family as well as he might have. There was a good deal of friction between the parents. The mother, aged thirty-two, was a nervous high-strung woman who was greatly concerned about Rose's illness and visited her frequently while she was hospitalized.

Marie was referred at the same time for convalescent placement. It was also thought that Marie was not well enough to return home, since she had a persistently elevated sedimentation rate, and the physical aspects of the home were not suitable for convalescence.

Marie's family consisted of her mother, aged forty-two, father, fifty-two, and five siblings besides Marie, ranging in age from twenty to thirteen. The home was overcrowded and poorly heated. Both parents and several of the older children were working, so that Marie would be unable to receive the close supervision that she needed during the convalescent period.

Since there seemed to be misunderstanding on the part of the Social Work Supervisor at the Sanatorium as to the pre-placement preparation and planning done by Children's Mission, an inter-agency conference was held. The sanatorium worker wondered why the child-placing worker would need to see the parents before placement was made, since she had already interpreted the function of the child-placing agency to the families. She had thought that the child-placing worker would write the parents notifying them of the transfer from the sanatorium to the foster home. The Children's Mission worker attempted to clarify the reason for seeing parents before placement, explaining that she would be able to establish a relationship with the parents and be able to assume casework responsibility where the sanatorium social worker had left off. A social history on the girls was not

Cases No. 5 and 6 - Rose and Marie

Rose, aged seven, and case number six, Marie, aged seven, were referred to Children's Mission by a doctor on the Rheumatic Fever Service, which was closing, at North Reading Sanatorium. Rose's home was not thought suitable to offer her convalescent care at this point in her illness.

Rose's family consisted of her parents and brother, a year older than Rose. Their apartment was on the top floor of a three tenement apartment house, and was poorly heated. The father, who was thirty-five years of age, was an irresponsible person who changed jobs frequently, and the mother claimed he never supported his family as well as he might have. There was a good deal of friction between the parents. The mother, aged thirty-two, was a nervous high-strung woman who was greatly concerned about Rose's illness and visited her frequently while she was hospitalized.

Marie was referred at the same time for convalescent placement. It was also thought that Marie was not well enough to return home, since she had a persistently elevated sedimentation rate, and the physical aspects of the home were not suitable for convalescence.

Marie's family consisted of her mother, aged forty-two, father, fifty-two, and five siblings besides Marie, ranging in age from twenty to thirteen. The home was overcrowded and poorly heated. Both parents and several of the older children were working, so that Marie would be unable to receive the close supervision that she needed during the convalescent period.

Since there seemed to be misunderstanding on the part of the Social Work Supervisor at the Sanatorium as to the pre-placement preparation and planning done by Children's Mission, an inter-agency conference was held. The sanatorium worker wondered why the child-placing worker would need to see the parents before placement was made, since she had already interpreted the function of the child-placing agency to the families. She had thought that the child-placing worker would write the parents notifying them of the transfer from the sanatorium to the foster home. The Children's Mission worker attempted to clarify the reason for seeing parents before placement, explaining that she would be able to establish a relationship with the parents and be able to assume casework responsibility where the sanatorium social worker had left off. A social history on the girls was not

sent until after the placement was made.

A group convalescent home was chosen for the two girls, since they were still bed patients. This is a group home for girls who are bed patients; it holds ten to twelve girls between the ages of five and fifteen years.

The same day, Marie's mother and older sister did come into the Children's Mission office to find out where Marie would be placed. They said that when Marie was told that she would be transferred to a Children's Mission foster home, she had cried and clung to her mother saying that she preferred to go home instead. The hospitalization at the sanatorium was the first time that Marie had been away from home. When the Children's Mission worker described the group home, Marie's mother expressed some apprehension, saying she had been assured by the doctor that the placement would not be in a foster home. The worker reassured the mother that the group home was actually a rest home. The mother stated that she would be unable to accompany Marie on the placement. Marie was not seen until the day of placement.

Rose's mother was not seen until the day of placement, but accompanied the worker to the placement with the two girls. Neither of the girls expressed any anxiety on the day of placement enroute to the foster home, and this seemed to be a happy experience.

During the time Rose and Marie were placed, both made very different adjustments. Rose was in placement for five months, during which time she increased her number of hours up per day and lowered her sedimentation rate. Rose was normally a physically active girl, vivacious and talkative. However, she had always stuttered, and during placement this symptom increased. Rose's stuttering was discussed with the parents who admitted that there was marital friction, and Rose had heard the parents discuss breaking up their home. Referral of Rose to a child guidance clinic for evaluation of the problem of her stuttering was made shortly after she left the foster home. Marie stayed in the foster home for a year's time because her sedimentation rate continued to remain so high. She continued throughout placement to be extremely reticent and submissive, unable to express negative feelings and always had to build herself up as a good girl. The parents of both girls visited frequently during placement.

sent until after the placement was made.

A group convalescent home was chosen for the two girls, since they were still bed patients. This is a group home for girls who are bed patients; it holds ten to twelve girls between the ages of five and fifteen years.

The same day, Marie's mother and older sister did come into the Children's Mission office to find out where Marie would be placed. They said that when Marie was told that she would be transferred to a Children's Mission foster home, she had cried and clung to her mother saying that she preferred to go home instead. The hospitalization at the sanatorium was the first time that Marie had been away from home. When the Children's Mission worker described the group home, Marie's mother expressed some apprehension, saying she had been assured by the doctor that the placement would not be in a foster home. The worker reassured the mother that the group home was actually a rest home. The mother stated that she would be unable to accompany Marie on the placement. Marie was not seen until the day of placement.

Rose's mother was not seen until the day of placement, but accompanied the worker to the placement with the two girls. Neither of the girls expressed any anxiety on the day of placement enroute to the foster home, and this seemed to be a happy experience.

During the time Rose and Marie were placed, both made very different adjustments. Rose was in placement for five months, during which time she increased her number of hours up per day and lowered her sedimentation rate. Rose was normally a physically active girl, vivacious and talkative. However, she had always stuttered, and during placement this symptom increased. Rose's stuttering was discussed with the parents who admitted that there was marital friction, and Rose had heard the parents discuss breaking up their home. Referral of Rose to a child guidance clinic for evaluation of the problem of her stuttering was made shortly after she left the foster home. Marie stayed in the foster home for a year's time because her sedimentation rate continued to remain so high. She continued throughout placement to be extremely reticent and submissive, unable to express negative feelings and always had to build herself up as a good girl. The parents of both girls stated frequently during placement.

DISCUSSION

Rose and Marie have been presented jointly because both were referred at the same time by the same worker. Both of these girls adjusted only moderately successfully to placement, for both of them exhibited anxiety throughout placement. Rose's stuttering increased so that she had to be referred to a child guidance clinic, and Marie, who had experienced her first separation from her family at the time of hospitalization, was withdrawn and had to impress everyone that she was a good little girl. Although the worker gave Marie an opportunity to express hostility and resentment, she was never able to do so during the course of placement.

There was almost no preparation of parents and children for the referral, and of the agency for the referrant, and little opportunity for the parents and child to be prepared adequately for the placement. It is very probable that poor preparation and sudden placement of these children may have contributed to their moderately successful adjustment in the foster home.

DISCUSSION

Rose and Marie have been presented jointly because both were referred at the same time by the same worker. Both of these girls adjusted only moderately successfully to placement, for both of them exhibited anxiety throughout placement. Rose's stuttering increased so that she had to be referred to a child guidance clinic, and Marie, who had experienced her first separation from her family at the time of hospitalization, was withdrawn and had to impress everyone that she was a good little girl. Although the worker gave Marie an opportunity to express hostility and resentment, she was never able to do so during the course of placement.

There was almost no preparation of parents and children for the referral, and of the agency for the referral, and little opportunity for the parents and child to be prepared adequately for the placement. It is very probable that poor preparation and sudden placement of these children may have contributed to their moderately successful adjustment in the foster home.

Case No. 7 - Harriet

A year's placement of Harriet, aged five, was requested by the Social Work Supervisor in the Salem Crippled Children's Orthopedic Clinic. Harriet was being followed in this clinic for poliomyelitis which she contracted at the age of nine months, and as a result of which she was left with involvement of the right leg, necessitating use of a brace.

The reason that placement was requested was that Harriet was unable to receive in her own home the supervision and rest that her medical condition required, because of extreme overcrowding and filth, and the mother's inability to cope with her large family, particularly Harriet's physical needs. The child had been making little medical progress in the home.

The family consisted of both parents and six children besides Harriet, ranging in age from ten to one year, with Harriet the third youngest child. The father, who was a taxi driver, earned thirty-five dollars a week which had to be supplemented by the Department of Public Welfare. Harriet had always been a weak baby, and at nine months began to appear somewhat ill, but the family did not notice anything serious until they were able to observe later that one of her legs was smaller than the other, and poliomyelitis was diagnosed. Harriet was first seen in the state orthopedic clinic when she was a year and a half, and placement at Lakeville Sanatorium was recommended because of the mother's inability to cope with the large family, and, in particular, Harriet's needs. Harriet remained at Lakeville for three years and had been at home for approximately six months when placement through Children's Mission was recommended. This period seemed to work out fairly well, since the parents were anxious to have their child at home and were anxious to do everything possible to make her adjustment easy. Some sort of routine was established in the family so that the mother was able to give some individual attention to the children and Harriet's orthopedic regime could be carried on in the home. However, the family were forced to vacate their apartment when the owner decided to take over occupancy, and the only solution that the family could make was to move in with a maternal aunt, which meant there were thirteen children and four adults occupying one apartment, which was dirty, disorderly and overcrowded. The family then found any routine difficult in this living situation, and consequently, Harriet was not receiving proper supervision at home which her medical condition required.

Case No. V - Harriet

A year's placement of Harriet, aged five, was requested by the Social Work Supervisor in the Salem Crippled Children's Orthopedic Clinic. Harriet was being followed in this clinic for poliomyelitis which she contracted at the age of nine months, and as a result of which she was left with involvement of the right leg, necessitating use of a brace.

The reason that placement was requested was that Harriet was unable to receive in her own home the supervision and rest that her medical condition required, because of extreme overcrowding and fifth, and the mother's inability to cope with her large family, particularly Harriet's physical needs. The child had been making little medical progress in the home.

The family consisted of both parents and six children besides Harriet, ranging in age from ten to one year, with Harriet the third youngest child. The father, who was a taxi driver, earned thirty-five dollars a week which had to be supplemented by the Department of Public Welfare. Harriet had always been a weak baby, and at nine months began to appear somewhat ill, but the family did not notice anything serious until they were able to observe later that one of her legs was smaller than the other, and poliomyelitis was diagnosed. Harriet was first seen in the state orthopedic clinic when she was a year and a half, and placement at Lakeville Sanatorium was recommended because of the mother's inability to cope with the large family, and, in particular, Harriet's needs. Harriet remained at Lakeville for three years and had been at home for approximately six months when placement through Children's Mission was recommended. This period seemed to work out fairly well, since the parents were anxious to have their child at home and were anxious to do everything possible to make her adjustment easy. Some sort of routine was established in the family so that the mother was able to give some individual attention to the children and Harriet's orthopedic regime could be carried on in the home. However, the family were forced to vacate their apartment when the owner decided to take over occupancy and the only solution that the family could make was to move in with a maternal aunt, which meant there were thirteen children and four adults occupying one apartment, which was dirty, disorderly and overcrowded. The family then found routine difficult in this living situation, and consequently, Harriet was not receiving proper supervision at home which her medical condition required.

Placement was recommended in the clinic, and the parents were at first reluctant to consider any plans for Harriet but after considerable interpretation of Harriet's medical needs because of her handicap, they agreed to placement because they realized they were unable to meet her needs. The father was insistent, however, of his right to have Harriet with the family as soon as their living conditions improved.

In a written summary to Children's Mission, the Social Work Supervisor included medical data that would be useful to the foster home, the reason for the referral, and a social summary of her contact with the family. In a subsequent visit to the agency, it was decided that casework responsibility would lie with the Services for Crippled Children, which had known the family over a number of years. Because there would be some delay in placement due to pressures within the agency, Harriet was placed temporarily away from her family in a foster home in the same town.

The foster home was selected by Children's Mission and had the negative aspect of being a long distance from the parents' home, but had the advantage of much warmth and affection, which is what Harriet needed. The Children's Mission worker gave the foster mother medical information and recommendations on Harriet to the foster mother, and explained that Harriet might have a little difficulty adjusting to the home because of previous separations.

The Children's Mission worker visited the family to discuss placement plans with them. The mother said she wanted very much to place Harriet and frankly said she was not too attached to the child, since Harriet had not lived with the family very much. She did not think Harriet was too close to the family, for the same reason. The mother anticipated placement for a short time, but when the worker mentioned a year, the mother accepted this readily. The mother was defensive about not having visited Harriet during the time she was at Lakeville, but said the distance was too far and she had too many responsibilities. The worker described the foster home to the parents and suggested that since it was nearer than Lakeville, the parents might be able to visit more often, explaining that there would be no restriction on visiting. The father was still somewhat defensive about placement, as he had been with the referring worker, but was unable to offer any other plan. The worker discussed with the parents how the placement might be carried out so that it would not be too traumatic for the little girl. It was decided that the parents would be present when the

worker took Harriet from the temporary foster home, although they admitted that they could not accompany the child on the placement. Harriet was also visited once by the Children's Mission worker in company with the referring worker, in order to establish some sort of relationship before the actual placement was made, but it was decided by both workers that it would be best for the child to absorb slowly the plan for placement as presented by the family and temporary foster mother.

On the day of placement, when the Children's Mission worker called for Harriet, the father was there, but was still defensive about signing the Children's Mission agreement forms, and did so only after considerable explanation. He was especially concerned about the hospitalization clause, giving the agency permission to hospitalize a child in an emergency without the parent's signature. The worker attempted to reassure the father that nothing would be "put over" on the family. There was no mention in the record whether or not Harriet had been told of the placement plans as anticipated by the workers. Harriet did not show any visible emotion other than excitement on departing from the home and her family, but during the drive to the foster home, did cry out her father's name several times.

Harriet remained in the same foster home for twenty-three months. At first, she presented overt behavior difficulties: aggressive and annoying behavior toward the foster siblings; defiance of the foster mother; and continual constipation which had no physical basis. She also expressed fantasies around death and violence in her parents. The worker thought that these symptoms might have been related to the family's failure to visit the child. During placement, the family never visited Harriet in the foster home, never wrote to her, and only visited her several times when she was seen in Crippled Children's Clinic. Throughout placement, Harriet exhibited extreme fear of abandonment, manifested in fear of being left alone or with strangers. Her family did finally find a larger place to live and preparation of Harriet for returning home consisted of two visits over weekends to her own home.

DISCUSSION

Harriet made only a moderately successful adjustment to the foster home placement. During her first three months in the foster home, her extreme insecurity was manifested in severe behavioral and psychosomatic symptoms, more specifically, extremely aggressive and annoying behavior with the foster siblings, continual disobedience of the foster mother, and chronic constipation that had no organic basis. She also expressed fantasies around death and violence to her parents which were indications of separation anxiety and fear that she might never see them again. Eventually, she did get along better with the foster siblings, became extremely fond of the foster mother, and exhibited no further psychosomatic symptoms. However, throughout her twenty-three months of placement, this child had extreme fears of abandonment. This was expressed by extreme anxiety at being left alone or with a stranger. The parents at no time visited the child in the foster home or wrote to her, but did see her several times when she had clinic appointments.

Although the parents admitted that they were unable to provide for Harriet's physical needs, it would seem that the referring worker did not adequately prepare them for placement, since the parents were still extremely defensive and resistant to the plan for placement by the time they were first seen by the Children's Mission worker. There was

DISCUSSION

Harriet made only a moderately successful adjustment to the foster home placement. During her first three months in the foster home, her extreme insecurity was manifested in severe behavioral and psychosomatic symptoms, more specifically, extremely aggressive and annoying behavior with the foster siblings, continual disobedience of the foster mother, and chronic constipation that had no organic basis. She also expressed fantasies around death and violence to her parents which were indications of separation anxiety and fear that she might never see them again. Eventually, she did get along better with the foster siblings, became extremely fond of the foster mother, and exhibited no further psychosomatic symptoms. However, throughout her twenty-three months of placement, this child had extreme fears of abandonment. This was expressed by extreme anxiety at being left alone or with a stranger. The parents at no time visited the child in the foster home or wrote to her, but did see her several times when she had clinic appointments. Although the parents admitted that they were unable to provide for Harriet's physical needs, it would seem that the referring worker did not adequately prepare them for placement, since the parents were still extremely defensive and resistant to the plan for placement by the time they were first seen by the Children's Mission worker. There was

adequate medical and social information sent to Children's Mission upon which the agency might base its pre-placement preparation and plans. A foster home was selected that would meet the child's physical and emotional needs, and the foster mother prepared for problems that Harriet might present during placement. In turn, it would seem that the Children's Mission worker did not adequately prepare the parents for placement since they were still hostile and defensive at the time the child was placed, and during Harriet's stay in the foster home the family had little contact with her. The child was seen but not told of placement plans by the child-placing worker, and there is no indication of how or if placement was interpreted to her by the parents or the temporary foster mother. Optimally, there should have been more time allowed by both workers for extensive preparation of parents and child for placement. Perhaps, Harriet might have been placed in a medical setting during the time that assistance was being given to the parents to help them overcome their resistances to placement. There may have been a very definite relationship between this child's extreme psychoneurotic and behavior symptoms during placement, and the inadequate preparation of parents and child for placement.

adequate medical and social information sent to Children's Mission upon which the agency might base its pre-placement preparation and plans. A foster home was selected that would meet the child's physical and emotional needs, and the foster mother prepared for problems that Harriet might present during placement. In turn, it would seem that the Children's Mission worker did not adequately prepare the parents for placement since they were still hostile and defensive at the time the child was placed, and during Harriet's stay in the foster home the family had little contact with her. The child was seen but not told of placement plans by the child-placing worker, and there is no indication of how or if placement was interpreted to her by the parents or the temporary foster mother. Optimally, there should have been more time allowed by both workers for extensive preparation of parents and child for placement. Perhaps, Harriet might have been placed in a medical setting during the time that assistance was being given to the parents to help them overcome their resistances to placement. There may have been a very definite relationship between this child's extreme psychoneurotic and behavior symptoms during placement, and the inadequate preparation of parents and child for placement.

Case No. 8 - Joan

Joan, aged nine, was referred by the Social Work Supervisor at the North Reading Rheumatic Fever Clinic to Children's Mission for placement because of many adverse emotional factors at home which were interfering with Joan's rest regime and general medical progress. Because the symptoms Joan exhibited were not completely characteristic of either rheumatic heart disease or rheumatoid arthritis, a definite diagnosis could not be made.

The family consisted of Joan's mother and father, both in their early thirties, and a brother, aged ten. Another child, who was born two years before Joan, died of burns when she was four. There was also a nephew, aged seven, living with the family. After Joan's birth, the mother had a hysterectomy because of difficult labor with all of her children. The mother generally showed a good deal of open rejection of Joan, who refused to obey and continually annoyed her, and the mother expressed fear that she might lose her temper and become physically abusive of the child. She felt that Joan dominated the whole house, and it was obvious that Joan's difficult behavior was causing friction between the parents, who did not agree on disciplining of her.

A year before, Joan was hospitalized for several months with acute rheumatic fever, and after discharge from the hospital lived for several months with her maternal grandmother because it was felt that the grandmother would be able to provide better housing for Joan during her convalescence. The grandmother told the clinic social worker that she felt that the mother both overindulged and overprotected Joan because of her illness. It was the feeling of the clinic personnel that the mother had never recovered from the shock of her daughter's death from burns, and for that reason, was apprehensive and constantly fearful that Joan's illness would also be fatal. At the same time, the mother actually seemed to want to be pessimistic about Joan's illness despite the interpretation of the hospital and clinic. The mother seemed to be obsessed with the idea that Joan's failure to gain weight and develop meant that she would die, and it was felt that perhaps the mother did want her daughter to die.

The clinic consultant had been concerned because Joan failed to gain weight and failed in general to make medical progress. The Social Work Supervisor in the clinic discussed the social situation with the consultants, and it was the consensus that, in the interests of her health, Joan should

be placed away from home, during which time every effort should be made to encourage the mother to accept psychiatric treatment. Referral to Children's Mission was discussed with the family. The mother was unwilling to consider placement with the grandmother again, because placement with a relative seemed to indicate, more than any other type of placement, the mother's failure. The mother would have preferred to place Joan in a hospital setting, since she seemed to want Joan to be ill and also such a placement would be less threatening to the mother. Joan's mother was unable to consider psychiatric help for herself or for Joan since she preferred to think of the problems on a medical or social basis. Joan seemed to be indifferent to the idea of placement, but, as the worker thought that the mother was interpreting placement as punishment, she attempted to discuss the placement plan with Joan in terms of medical need.

An application was made to Children's Mission. Included in the summary was medical information and recommendations, the meaning of Joan's illness, particularly to the mother, the mother's relationship with Joan, and the feelings of both toward separation and placement. Jointly, it was decided that casework responsibility in regard to referral of the mother for psychiatric help would lie with the clinic worker.

The Children's Mission worker saw both of the parents in the office. The worker gave a brief explanation of the function of the Children's Mission and of the foster home where Joan would be placed. Arrangements were made for the mother to accompany Joan to the placement. The mother stated emphatically that she would not visit Joan in the foster home, so that Joan would learn to appreciate her own home, but that she would plan to see Joan in clinic when Joan was seen by the doctors. The need for frequent contact with the child during placement was not gone into with the parents. Joan was not seen before placement was made.

Joan's placement lasted ten months, during which time she did gain weight, made medical progress, and became more outgoing than she was at the time she was placed. As the mother stated in her pre-placement interview with the child-placing worker, she saw Joan during placement only at clinic. Joan exhibited throughout placement many nervous mannerisms which at first were thought to be chorea, but then were thought to be more in the nature of tics. She also never overcame the habit that she had at home of constantly licking her lower lip, so that she was seldom free of a sore there. At no time was the mother able to accept psychiatric treatment for herself.

profit enough from more adequate pre-placement preparation

be placed away from home, during which time every effort should be made to encourage the mother to accept psychiatric treatment. Referral to Children's Mission was discussed with the family. The mother was unwilling to consider placement with the grandmother again, because placement with a relative seemed to indicate, more than any other type of placement, the mother's failure. The mother would have preferred to place Joan in a hospital setting, since she seemed to want Joan to be ill and also such a placement would be less threatening to the mother. Joan's mother was unable to consider psychiatric help for herself or for Joan since she preferred to think of the problems on a medical or social basis. Joan seemed to be indifferent to the idea of placement, but, as the worker thought that the mother was interpreting placement as punishment, she attempted to discuss the placement plan with Joan in terms of medical need.

An application was made to Children's Mission. Included in the summary was medical information and recommendations, the meaning of Joan's illness, particularly to the mother, the mother's relationship with Joan, and the feelings of both toward separation and placement. Jointly, it was decided that casework responsibility in regard to referral of the mother for psychiatric help would lie with the clinic worker.

The Children's Mission worker saw both of the parents in the office. The worker gave a brief explanation of the function of the Children's Mission and of the foster home where Joan would be placed. Arrangements were made for the mother to accompany Joan to the placement. The mother stated emphatically that she would not visit Joan in the foster home, so that Joan would learn to appreciate her own home, but that she would plan to see Joan in clinic when Joan was seen by the doctors. The need for frequent contact with the child during placement was not gone into with the parents. Joan was not seen before placement was made.

Joan's placement lasted ten months, during which time she did gain weight, made medical progress, and became more outgoing than she was at the time she was placed. As the mother stated in her pre-placement interview with the clinic placing worker, she saw Joan during placement only at clinic. Joan exhibited throughout placement many nervous mannerisms which at first were thought to be chores, but then were thought to be more in the nature of tics. She also never overcame the habit that she had at home of constantly licking her lower lip, so that she was seldom free of a sore there. At no time was the mother able to accept psychiatric treatment for herself.

DISCUSSION

Joan's adjustment to foster home placement was only moderately successful. Although she made medical progress when freed from the emotional tension in her own home, and she became more outgoing throughout placement, she manifested severe nervous mannerisms, which at no time was the foster mother able to alleviate.

It was obvious that the mother was using both the placement and her failure to visit Joan in the foster home as punishment. Although the referring worker interpreted placement to the child on the basis of her medical needs, it is probable that Joan also viewed placement as a punishment and perhaps abandonment because of her own difficult behavior at home and extreme hostility toward her mother. There was no indication that the mother's feelings toward placement were sufficiently worked through nor the need for frequent visiting interpreted. The mother had reached the point where she was unable to cope with Joan's difficult behavior, but there are indications that placement other than hospitalization would indicate her own failures as a mother. Joan was not seen by the child-placing worker before placement, so that there was no opportunity to work through her feelings toward separation, either.

Perhaps Joan's mother was too disturbed to be able to profit enough from more adequate pre-placement preparation

to give Joan the support she needed during placement. However, if Joan had been more thoroughly prepared for placement, some of her extreme psychoneurotic symptoms might have been alleviated.

The following three cases did not make a successful adjustment to placement. Unsuccessful adjustment is defined as one in which the child was unable to tolerate placement and ran away or asked for removal; one in which the parent was unable to tolerate placement and asked for the removal of the child; or one in which the problems of the child were so severe that the agency had to remove the child.

Of these three children, two were boys and one a girl, the oldest fourteen years old, the youngest five months. The first child, who had multiple handicaps, was referred for placement in order to be built up to the point where he might enter a school for the deaf. The second child was referred for a year's placement until a more careful diagnosis and prognosis of the child's handicaps might be made. The third was referred for summer placement because emotional tension in his home was impeding his medical progress. In two of the three cases, preparation was adequate, but in one of these the problems were too severe for foster home placement; in the other the parents, because of their own feelings around the child's handicaps, were unable to keep the child in placement. In the last case, the child, who was inadequately prepared for placement, ran

CHAPTER VII

THREE CASES OF CHILDREN WHOSE ADJUSTMENT TO PLACEMENT
WAS UNSUCCESSFUL

The following three cases did not make a successful adjustment to placement. Unsuccessful adjustment is defined as one in which the child was unable to tolerate placement and ran away or asked for removal; one in which the parent was unable to tolerate placement and asked for the removal of the child; or one in which the problems of the child were so severe that the agency had to remove the child.

Of these three children, two were boys and one a girl, the oldest fourteen years old, the youngest five months. The first child, who had multiple handicaps, was referred for placement in order to be built up to the point where he might enter a school for the deaf. The second child was referred for a year's placement until a more careful diagnosis and prognosis of the child's handicaps might be made. The third was referred for summer placement because emotional tension in his home was impeding his medical progress. In two of the three cases, preparation was adequate, but in one of these the problems were too severe for foster home placement; in the other the parents, because of their own feelings around the child's handicaps, were unable to keep the child in placement. In the last case, the child, who was inadequately prepared for placement, ran

THREE CASES OF CHILDREN WHOSE ADJUSTMENT TO PLACEMENTWAS UNSUCCESSFUL

The following three cases did not make a successful adjustment to placement. Unsuccessful adjustment is defined as one in which the child was unable to tolerate placement and ran away or asked for removal; one in which the parent was unable to tolerate placement and asked for the removal of the child; or one in which the problems of the child were so severe that the agency had to remove the child.

Of these three children, two were boys and one a girl, the oldest fourteen years old, the youngest five months. The first child, who had multiple handicaps, was referred for placement in order to be built up to the point where he might enter a school for the deaf. The second child was referred for a year's placement until a more careful diagnosis and prognosis of the child's handicaps might be made. The third was referred for summer placement because emotional tension in his home was impeding his medical progress. In two of the three cases, preparation was adequate, but in one of these the problems were too severe for foster home placement; in the other the parents, because of their own feelings around the child's handicaps, were unable to keep the child in placement. In the last case, the child, who was inadequately prepared for placement, ran

away from the first placement and asked for removal from the second.

Harry, aged six, was referred by the Social Work Supervisor at Lakeville State Sanatorium for foster home placement until he might be ready to enter a school for the deaf. Harry's family were unable to provide him with the care he needed, since they were overburdened by economic pressures and a large family. Harry was diagnosed to have arrested pulmonary tuberculosis, tubercular meningitis with deafness, spastic paralysis of his left leg, paralytic bladder, and atrophy of the left lower leg.

Harry's father, who was twenty-nine and a kitchen helper, earned approximately eight dollars a day. The mother was twenty-four. There were five children to support. Their home was located in a rural area of the state, with poor toilet facilities and overcrowding. Harry's illness began at the age of one and a half when he contracted pulmonary tuberculosis and tubercular meningitis through his paternal grandfather, who was living in the home at the time. Harry was admitted to a Rhode Island hospital and then transferred to the state sanatorium, the two hospitalizations lasting sixteen months. After treatment with streptomycin for the tuberculosis, Harry was left with almost total deafness; the meningitis left Harry with a multiplicity of handicaps, including atrophy and spastic paralysis of the left leg. He was discharged from the state sanatorium to his home, where he stayed for two months, but the parents, although they were fond of and interested in Harry, found care of him too much of a burden. After this short period at home, Harry, who was being followed in a Crippled Children's Orthopedic Clinic, was admitted to Lakeville Sanatorium for treatment of his spastic paralysis and atrophy of his left leg. Harry stayed at Lakeville for three and a half years, during which time he managed to learn to get around on a brace and crutches. At the time of discharge, medical recommendations were that Harry be discharged to a school for the deaf. Application was made to a school for the deaf, but was not accepted because Harry did not have control of his bladder.

Application was made to Children's Mission for summer placement until Harry might have enough control of his bladder for him to be admitted to a school for the deaf. Referral had been discussed with the parents, who agreed to the plan for foster home placement. In the summary which the Social Work Supervisor at Lakeville sent to Children's Mission, she included all medical history, a social summary on the family, and a summary of Harry's behavior while at Lakeville. While there, he had been somewhat of a behavior

Case No. 9 - Harry

Harry, aged six, was referred by the Social Work Supervisor at Lakeville State Sanatorium for foster home placement until he might be ready to enter a school for the deaf. Harry's family were unable to provide him with the care he needed, since they were overburdened by economic pressures and a large family. Harry was diagnosed to have arrested pulmonary tuberculosis, tubercular meningitis with deafness, spastic paralysis of his left leg, paralytic bladder, and atrophy of the left lower leg.

Harry's father, who was twenty-nine and a kitchen helper, earned approximately eight dollars a day. The mother was twenty-four. There were five children to support. Their home was located in a rural area of the state, with poor toilet facilities and overcrowding. Harry's illness began at the age of one and a half when he contracted pulmonary tuberculosis and tubercular meningitis through his paternal grandfather, who was living in the home at the time. Harry was admitted to a Rhode Island hospital and then transferred to the state sanatorium, the two hospitalizations lasting sixteen months. After treatment with streptomycin for the tuberculosis, Harry was left with almost total deafness; the meningitis left Harry with a multiplicity of handicaps, including atrophy and spastic paralysis of the left leg. He was discharged from the state sanatorium to his home, where he stayed for two months, but the parents, although they were fond of and interested in Harry, found care of him too much of a burden. After this short period at home, Harry, who was being followed in a Crippled Children's Orthopedic Clinic, was admitted to Lakeville Sanatorium for treatment of his spastic paralysis and atrophy of his left leg. Harry stayed at Lakeville for three and a half years, during which time he managed to learn to get around on a brace and crutches. At the time of discharge, medical recommendations were that Harry be discharged to a school for the deaf. Application was made to a school for the deaf, but was not accepted because Harry did not have control of his bladder.

Application was made to Children's Mission for summer placement until Harry might have enough control of his bladder for him to be admitted to a school for the deaf. Referral had been discussed with the parents, who agreed to the plan for foster home placement. In the summary which the Social Work Supervisor at Lakeville sent to Children's Mission, she included all medical history, a social summary on the family, and a summary of Harry's behavior while at Lakeville. While there, he had been somewhat of a behavior

problem, since he was extremely active and difficult to control. He was described as mentally alert and teachable. Some of his behavior problems consisted of continually undressing himself, ripping clothes and bedding and being generally very destructive. With other children, he was loud and abusive and they feared him. The only time that he was quiet was when someone was giving him sole attention, and he was extremely affectionate with anyone who gave him attention.

The Children's Mission worker made a visit to the family to discuss with them placement plans. The mother told the worker of the difficulty the family had when they had taken Harry home for a few days at Christmas, for they did not know how to handle him and were unable to give him all the attention that he needed. The mother stated that the father had always been the active one in making plans for Harry, that she had been unable to do so because there had been no one to leave with the other children, but that she was grateful that the worker was able to make a home visit so that she could participate in the planning. The Children's Mission worker interpreted the function of the agency and described to the mother what the foster home would be like, where Harry would most likely be placed. The worker stressed the plan that Harry would be placed for only a temporary period, until he reached the point where he would be able to go into a school for the deaf. She asked that the parents, or at least one of them, accompany Harry on the placement and interpreted that this would make the placement easier for Harry.

The worker visited Harry at Lakeville once before the actual placement was made to get acquainted with him, to observe him, and to make final arrangements for placement with the staff at Lakeville. Harry was told of the placement plans, and of the foster home where he would be placed.

A foster home was selected where the foster mother was a nurse with years of experience with seriously handicapped children placed by Children's Mission. She had been successful with both serious medical problems and behavior problems, too, and took a warm interest in children.

Harry's father met the Children's Mission worker at Lakeville on the day of placement, and accompanied Harry on the placement. The worker had the impression that the father was very much attached to Harry and determined to do anything possible to help him get along. Harry actually stayed in this home five months. In the home, he exhibited much of the same difficult behavior that he had at Lakeville: tearing sheets, being physically abusive toward younger children in

the home and generally being very destructive. Physically, he seemed to be gaining some ground, for he had almost complete control of his bowels, although he still did not have control of his bladder. After five months, Harry was removed from the foster home, for his trial placement was up and new plans for his care would have to be made. The foster mother thought the child did not belong in a foster home but should be with other children with the same sort of problems. Harry lived with his own family for three months, during which time the agencies attempted to make other plans. In an inter-agency conference, it was decided to admit Harry to a Boston hospital where all phases of his handicaps might be studied. This hospitalization lasted close to eight months and was financed by Services for Crippled Children. Harry improved physically during his hospital stay, attained some bladder control, and ulcers on his heel caused by rubbing of the brace were treated until he was able again to walk with crutches. In the meantime, Children's Mission attempted to find another foster home suitable for this child. No school for the deaf would take him, again because of the multiplicity of handicaps. Finally a private institution for crippled children was found that would take Harry, with provision for speech and hearing training made from the outside. Harry was placed in this institution, where he has remained for eight months.

DISCUSSION

This foster home placement was not actually a success, although pre-placement preparation of parents and child and selection of the foster home were adequate.

The foster home selected was one that Children's Mission had used frequently for its most difficult medical and emotional problems. The foster mother, who was a registered nurse, was flexible and offered a great deal of warmth and interest in working with the most difficult medical and emotional problems. Harry, however, was not yet ready for a foster home as was demonstrated; he needed more careful medical supervision than he could get in a foster home. Also, his behavior problems were very disturbing in the home and ones that the ordinary foster home would be unable to tolerate. Although the foster mother did not ask for Harry's removal, she suggested that he be placed in other than a foster home placement. Although preparation of Harry and of his parents was adequate, and although a good foster home was selected, Harry's medical and behavioral problems were too severe for him to make a satisfactory adjustment.

DISCUSSION

This foster home placement was not actually a success, although pre-placement preparation of parents and child and selection of the foster home were adequate.

The foster home selected was one that Children's Mission had used frequently for its most difficult medical

and emotional problems. The foster mother, who was a registered nurse, was flexible and offered a great deal of warmth and interest in working with the most difficult medi-

cal and emotional problems. Harry, however, was not yet ready for a foster home as was demonstrated; he needed more

careful medical supervision than he could get in a foster home. Also, his behavior problems were very disturbing in

the home and ones that the ordinary foster home would be unable to tolerate. Although the foster mother did not ask

for Harry's removal, she suggested that he be placed in other than a foster home placement. Although preparation

of Harry and of his parents was adequate, and although a good foster home was selected, Harry's medical and behavioral

problems were too severe for him to make a satisfactory

adjustment.

Case No. 10 - Ann

Ann, aged five months, was referred for placement in a Children's Mission home, by the Social Work Supervisor in the Haverhill Crippled Children's Clinic. Ann had a diagnosis of arthrogryposis, multiple bone and joint deformities, underdevelopment of the musculature of the body, dwarfism and questionable mental retardation. Placement was requested on the basis of the mother's poor health as a former tuberculosis patient, and the need for specialized type of care for this child. A year's placement was requested, after which time the doctors felt that a more accurate diagnosis and prognosis of her physical and mental handicaps could be made.

Ann was the only child by her mother's second marriage; her father's first. There was a girl, aged eleven by the mother's first marriage, a bright, physically normal child. Both parents were shocked to give birth to a baby so grossly deformed and felt it was unfair, especially since they had wanted the baby so much. The mother had had difficulty in becoming pregnant, and for some time had been under the care of an obstetrician. Both parents had many guilt feelings about their responsibility in producing a deformed child, especially the mother, who had taken care of her ill father during her pregnancy and wondered whether she had assumed too much. The father had been so disappointed in having this child that he feared having further children. The parents were also concerned about the effect that Ann's deformity might have on the older child, and feared that this girl would never have the social life and contacts with other children to which they felt she was entitled.

Referral had originally been made to Crippled Children's Services for payment of care in the hospital where the parents had admitted her for treatment. Casework responsibility at this point was assumed by Crippled Children's Services, and in joint planning with the hospital social worker who had seen the parents on several occasions, it was decided that Ann would not be able to return home at this time. The Public Health Social Work Supervisor had several interviews with the parents in order to explore their feelings around having such a deformed child and to help them plan for her care. At first, the parents had been so overpowered and upset by the situation that they were unable to talk together about it, but gradually they overcame their intense feeling. The Social Work Supervisor interpreted to the parents that a complete diagnosis and prognosis of the baby's physical and mental condition could not be done for

at least a year. In talking with her, the parents reviewed many of the various plans that they had discussed with the hospital worker. Among these, was the fact that they knew a local representative who had urged the parents to file an application to the Wrentham School for the Feeble-Minded. The parents recognized at that time it would not be advisable unless recommended by the doctors. The possibility of foster home placement through Children's Mission for a year until a more careful diagnosis and prognosis could be made was discussed with the parents who were immediately responsive to the referral and to the idea of placement. Children's Mission was chosen because of the specialized type of care this child would need.

Referral to Children's Mission was made by phone and later confirmed by letter. Included in the letter was complete information on Ann's multiple handicaps; detailed information on the family, of a financial and social nature, and the feelings of the parents around the baby's handicap and the effect that it might have on the family if Ann were taken home. It was suggested that the parents might need a good deal of reassurance and understanding and casework help around future plans for the child. It was thought that at no time had the parents considered taking Ann home, and that there probably would be no guilt over the placement. It was explained that though medical supervision could be assumed by Crippled Children's Services, they would be able to assume no financial responsibility. Jointly, it was decided that casework responsibility would be carried by Children's Mission during placement.

The parents were interviewed twice by the Children's Mission worker, around placement plans and their feelings about placement. The worker attempted to alleviate some of the parents' guilt feelings having a deformed baby, and to encourage them to have other children. The foster home and foster mother were described to the parents, and a pre-placement visit made by them to see the home. They were encouraged to visit the child regularly in the foster home. The parents expressed the fear that they would not be allowed to visit Ann in the foster home, and the worker interpreted to them that the agency felt that regardless of whether or not a family ever took a child home, it was important for the child to see and know his parents. It was the worker's impression that the mother was perhaps too dependent an individual herself to assume the role of motherhood, and that, because of responsibility for the maternal grandmother, who had recently had a nervous breakdown and was living with the family, and the distance the family lived from Boston, it might be difficult to carry on much more extensive casework with this family.

Ann was in placement for six months, during which time the parents were seen several times by the Children's Mission worker. The parents had made application through a political representative for Wrentham, and seemed relieved to have finally made a decision. They visited the baby frequently. During this time, a psychological test was done, but it was felt that valid conclusions could be obtained only from a series of tests given over a long period of time. There was definite improvement shown in Ann's medical status, due to both cast care and also to the foster mother's conscientious administering of exercises. After six months of placement, the parents removed Ann from placement to admit her to Wrentham.

DISCUSSION

It would seem from the fact the parents were unable to keep this baby in placement the agreed length of time that the placement was not successful. The original plan for the length of placement had been at least a year, after which time it would be easier to make a more careful diagnosis and prognosis of the child's handicaps and future.

There had been extensive preparation of the parents for placement on the part of both the referring social worker in the Crippled Children's Clinic and the Children's Mission worker. Both workers had attempted to dispel the parents' feelings of shame and guilt around having a child with such a severe deformity, and to help the father resolve his conflict in regard to having the child return home after a year's time. The father did succeed in working through this conflict so that he was able to make application to Wrentham for eventual care of the child. However, the parents were so blocked by their feelings about having a baby so deformed, physically and mentally, that they were unable to work through these feelings, despite the extensive help offered, demonstrating the need to rid themselves of the responsibility for this child.

DISCUSSION

It would seem from the fact the parents were unable to keep this baby in placement the agreed length of time that the placement was not successful. The original plan for the length of placement had been at least a year, after which time it would be easier to make a more careful diagnosis and prognosis of the child's handicaps and future. There had been extensive preparation of the parents for placement on the part of both the referring social worker in the Crippled Children's Clinic and the Children's Mission worker. Both workers had attempted to dispel the parents' feelings of shame and guilt around having a child with such a severe deformity, and to help the father resolve his conflict in regard to having the child return home after a year's time. The father did succeed in working through this conflict so that he was able to make application to Wrentham for eventual care of the child. However, the parents were so blocked by their feelings about having a baby so deformed, physically and mentally, that they were unable to work through these feelings, despite the extensive help offered, demonstrating the need to rid themselves of the responsibility for this child.

Case No. 11 - Donald

This fourteen year old boy was referred to Children's Mission for summer placement by the Social Work Supervisor at the North Reading Rheumatic Fever Clinic. Donald was being followed at this clinic at frequent intervals for close medical supervision because of serious rheumatic heart disease. Because of his serious health problems and behavior problems, as well as emotional tension within the family, temporary placement was requested for the summer months, with the plan of possible transfer to a boarding school in the fall. It was felt that the emotional situation in the home was retarding Donald's medical progress.

Donald was one of six siblings, four older and two younger, of parents in their middle forties. His father, who had a moderate income as a bank teller in the well-to-do community where the family resided, had had to supplement his income with financial help from various relatives on both sides of the family. The mother claimed that the father's alcoholism, which had never interfered with his work, was causing a good deal of financial strain as well as emotional tension within the family. According to the mother, the effect of the father's alcoholism on the family members had been disastrous, and the only thing that had spared her older children from having breakdowns was the fact that they had all left home at an early age. All of the children were known to a local child guidance clinic because of various behavior and school problems. Donald was the only one who had stood up against his father. He and his father had quarrelled frequently, and at such times the mother had become frightened because Donald's heart action would increase. In the past year, Donald had done some stealing and been known to the police. The mother had been so concerned about the emotional strain in the family that she had been to the local Society for the Prevention of Cruelty to Children to see if they would take any legal action against the father.

Donald had been ill with rheumatic fever at home for eighteen months. Some physical restrictions were recommended by the clinic, but Donald was considered to be the active one in the family. The mother felt that Donald was aware of his cardiac diagnosis, but had taken the attitude that if heart disease was going to kill him, it might as well be in the present as in the future. Donald thought his father disliked him because he reminded him of a paternal uncle who had heart disease. The father, who apparently could not accept Donald's limitations, seemed to think he was cured.

Case No. 11 - Donald

This fourteen year old boy was referred to Children's Mission for summer placement by the Social Work Supervisor at the North Reading Rheumatic Fever Clinic. Donald was being followed at this clinic at frequent intervals for close medical supervision because of serious rheumatic heart disease. Because of his serious health problems and behavior problems, as well as emotional tension within the family, temporary placement was requested for the summer months, with the plan of possible transfer to a boarding school in the fall. It was felt that the emotional situation in the home was retarding Donald's medical progress.

Donald was one of six siblings, four older and two younger, of parents in their middle forties. His father, who had a moderate income as a bank teller in the well-to-do community where the family resided, had had to supplement his income with financial help from various relatives on both sides of the family. The mother claimed that the father's alcoholism, which had never interfered with his work, was causing a good deal of financial strain as well as emotional tension within the family. According to the mother, the effect of the father's alcoholism on the family members had been disastrous, and the only thing that had spared her older children from having breakdowns was the fact that they had all left home at an early age. All of the children were known to a local child guidance clinic because of various behavior and school problems. Donald was the only one who had stood up against his father. He and his father had quarrelled frequently, and at such times the mother had become frightened because Donald's heart action would increase. In the past year, Donald had done some stealing and been known to the police. The mother had been so concerned about the emotional strain in the family that she had been to the local Society for the Prevention of Cruelty to Children to see if they would take any legal action against the father.

Donald had been ill with rheumatic fever at home for eighteen months. Some physical restrictions were recommended by the clinic, but Donald was considered to be the active one in the family. The mother felt that Donald was aware of his cardiac diagnosis, but had taken the attitude that if heart disease was going to kill him, it might as well be in the present as in the future. Donald thought his father disliked him because he reminded him of a paternal uncle who had heart disease. The father, who apparently could not accept Donald's limitations, seemed to think he was cured.

Donald's mother initiated with the Social Work Supervisor discussion of placement of Donald for the summer months. Referral to Children's Mission was offered, with the mother readily accepting the idea. A letter of referral by the clinic social worker was sent to Children's Mission including medical information, the attitudes of various members of the family toward Donald's illness, and medical recommendations made by the clinic. Also included was a detailed summary of the social and emotional problems within the family, Donald's behavior problems, and the family's contacts with various social and psychiatric agencies in the community.

A conference was held with the psychiatrist who had known the family at the child guidance clinic, the Society for the Prevention of Cruelty to Children worker, the clinic Social Work Supervisor, and the Children's Mission worker, in order to make a more careful diagnosis of the need for placement, how this might be effected, and to define the casework responsibility of each of the represented agencies. Through the combined information offered by each of the workers, it was determined that, ideally, long-term placement seemed indicated because of the tension in the home which seemed to be retarding Donald's medical progress. However, it was felt that the father would only accept placement on the basis of medical necessity, and that if the clinic consultant discussed the seriousness of Donald's condition the father would be better able to accept placement. It was decided that the Society for the Prevention of Cruelty to Children worker would continue to offer casework services to the mother on family problems and the Children's Mission worker would work with the family around placement.

The Children's Mission worker saw the family twice before placement, Donald on the last of these visits, in the presence of the family. Donald did not express too much enthusiasm, but was urged by his mother to accept the plan of going to a foster home where he would be away from disagreeable experiences in the home.

The original plan was to place Donald on a farm foster home; however, the foster mother withdrew her application the day before placement was to be made. Arrangements were made to place Donald at the small school for disturbed boys in New Hampshire that the mother had first suggested and which the agency had occasionally used. The only physical restrictions that Donald would have in this environment would be in competitive sports and mountain climbing. The mother accompanied Donald and the Children's Mission worker on the placement, and information regarding medical recommendations and some of Donald's behavior problems were given to the school.

Donald's mother initiated with the Social Work Supervisor a discussion of placement of Donald for the summer months. Referral to Children's Mission was offered, with the mother readily accepting the idea. A letter of referral by the clinic social worker was sent to Children's Mission including medical information, the attitudes of various members of the family toward Donald's illness, and medical recommendations made by the clinic. Also included was a detailed summary of the social and emotional problems within the family, Donald's behavior problems, and the family's contacts with various social and psychiatric agencies in the community.

A conference was held with the psychiatrist who had known the family at the child guidance clinic, the Society for the Prevention of Cruelty to Children worker, the clinic Social Work Supervisor, and the Children's Mission worker, in order to make a more careful diagnosis of the need for placement, how this might be effected, and to define the casework responsibility of each of the represented agencies. Through the combined information offered by each of the workers, it was determined that, ideally, long-term placement seemed indicated because of the tension in the home which seemed to be retarding Donald's medical progress. However, it was felt that the father would only accept placement on the basis of medical necessity, and that if the clinic consultant discussed the seriousness of Donald's condition the father would be better able to accept placement. It was decided that the Society for the Prevention of Cruelty to Children worker would continue to offer casework services to the mother on family problems and the Children's Mission worker would work with the family around placement.

The Children's Mission worker saw the family twice before placement, Donald on the last of these visits, in the presence of the family. Donald did not express too much enthusiasm, but was urged by his mother to accept the plan of going to a foster home where he would be away from disagreeable experiences in the home.

The original plan was to place Donald on a farm foster home; however, the foster mother withdrew her application the day before placement was to be made. Arrangements were made to place Donald at the small school for disturbed boys in New Hampshire that the mother had first suggested and which the agency had occasionally used. The only physical restrictions that Donald would have in this environment would be in competitive sports and mountain climbing. The mother accompanied Donald and the Children's Mission worker on the placement, and information regarding medical recommendations and some of Donald's behavior problems were given to the school.

Several days after placement was made, Donald ran away from the school to return to his own home. In an interview which the Children's Mission worker had alone with him, he expressed the feeling that he had been forced into accepting placement, that placement would be permanent and that he could not participate in all of the activities at the school because of physical restrictions. Donald was also upset by some of the behavior problems other boys at the school exhibited. He expressed a desire to be placed for the summer, but preferred to be sent to a camp that he had attended a previous summer. With the approval of the clinic team, Donald was placed in this camp, and seemed to be contented, but within two weeks had to be hospitalized because of a high temperature. The possibility of recurrence of rheumatic fever was ruled out, but Donald stated that he preferred to go home rather than return to the camp, and such arrangements were made.

Donald was placed in a small school for disturbed boys. When Donald was placed there, he was upset by some of the other boys' behavior and he feared that placement would be permanent. Donald probably had much guilt about his hostility toward his father and his behavior at home, and, for this reason found it difficult to tolerate placement, particularly in a school for disturbed boys. He also found placement at the school difficult because he could not participate in all of the sports because of his own physical limitations. This may have been threatening to the boy because of his own feelings about having a cardiac diagnosis, his need to compete, and a feeling that he was an outcast from the group. Donald requested placement in a summer camp, which would be more tolerable for this boy since he had already attended this camp before, and it was an environment where boys who hadn't misbehaved were sent for a summer's vacation. However, he had to be hospitalized after several weeks in camp.

and then requested to

DISCUSSION

There would seem to be several factors that contributed to Donald's failure to accept and adjust to placement.

Donald had not actually participated in planning for his placement, and later, after he had run away from the placement, admitted that he felt that he had been pushed into accepting placement. At the last minute, the choice of a placement had to be changed from an individual foster home to a small school for disturbed boys. When Donald was placed there, he was upset by some of the other boys' behavior and he feared that placement would be permanent.

Donald probably had much guilt about his hostility toward his father and his behavior at home, and, for this reason found it difficult to tolerate placement, particularly in a school for disturbed boys. He also found placement at the school difficult because he could not participate in all of the sports because of his own physical limitations. This may have been threatening to the boy because of his own feelings about having a cardiac diagnosis, his need to compete, and a feeling that he was an outcast from the group. Donald requested placement in a summer camp, which would be more tolerable for this boy since he had already attended this camp before, and it was an environment where boys who hadn't misbehaved were sent for a summer's vacation. However, he had to be hospitalized after several weeks in camp,

DISCUSSION

There would seem to be several factors that contributed

to Donald's failure to accept and adjust to placement.

Donald had not actually participated in planning for his placement, and later, after he had run away from the place-

ment, admitted that he felt that he had been pushed into accepting placement. At the last minute, the choice of a placement had to be changed from an individual foster home

to a small school for disturbed boys. When Donald was

placed there, he was upset by some of the other boys'

behavior and he feared that placement would be permanent.

Donald probably had much guilt about his hostility toward

his father and his behavior at home, and, for this reason

found it difficult to tolerate placement, particularly in

a school for disturbed boys. He also found placement at the

school difficult because he could not participate in all of

the sports because of his own physical limitations. This

may have been threatening to the boy because of his own

feelings about having a cardiac diagnosis, his need to com-

pete, and a feeling that he was an outcast from the group.

Donald requested placement in a summer camp, which would be

more tolerable for this boy since he had already attended

this camp before, and it was an environment where boys who

hadn't misbehaved were sent for a summer's vacation. How-

ever, he had to be hospitalized after several weeks in camp,

and then requested to be sent home.

There was good preparation for the referral and of the parents for placement, but poor preparation of the boy, who had many strong feelings about placement which might have been worked through, had he had the opportunity to participate more directly and independently of his parents in planning for his placement.

The writer studied eleven cases known to the Services for Crippled Children of the Massachusetts Department of Public Health and accepted for placement in medical foster homes of Children's Mission to Children between July, 1947, and July, 1953. The primary purpose of the study was to evaluate the adjustment of the eleven children to placement, and to determine whether the degree of pre-placement planning and preparation contributed to the success or failure of each child's adjustment in the foster home. The areas in pre-placement planning and preparation considered were: the factors determining need for placement; preparation of the parent and child for the referral; preparation of the child-placing agency for the referral; selection of the foster home; and preparation of the family and child for placement by the child-placing agency.

The cases were classified in the following manner: four cases of children whose adjustments to placement were successful; four cases of children whose adjustments to placement were only moderately successful; and three cases of children whose adjustments to placement were unsuccessful. Successful adjustment was defined as one in which the child exhibited no serious psychoneurotic or behavior disturbances beyond the first few weeks of placement. Moderately successful adjust-

and then requested to be sent home.

There was good preparation for the referral and of the

parents for placement, but poor preparation of the boy, who

had many strong feelings about placement which might have

been worked through, had he had the opportunity to participate

more directly and independently of his parents in planning

for his placement.

CHAPTER VIII

SUMMARY AND CONCLUSIONS

The writer studied eleven cases known to the Services for Crippled Children of the Massachusetts Department of Public Health and accepted for placement in medical foster homes of Children's Mission to Children between July, 1947, and July, 1953. The primary purpose of the study was to evaluate the adjustment of the eleven children to placement, and to determine whether the degree of pre-placement planning and preparation contributed to the success or failure of each child's adjustment in the foster home. The areas in pre-placement planning and preparation considered were: the factors determining need for placement; preparation of the parent and child for the referral; preparation of the child-placing agency for the referral; selection of the foster home; and preparation of the family and child for placement by the child-placing agency.

The cases were classified in the following manner: four cases of children whose adjustments to placement were successful; four cases of children whose adjustments to placement were only moderately successful; and three cases of children whose adjustments to placement were unsuccessful. Successful adjustment was defined as one in which the child exhibited no serious psychoneurotic or behavior disturbances beyond the first few weeks of placement. Moderately successful adjust-

CHAPTER VIII

SUMMARY AND CONCLUSIONS

The writer studied eleven cases known to the Services for Crippled Children of the Massachusetts Department of Public Health and accepted for placement in medical foster homes of Children's Mission to Children between July, 1947, and July, 1953. The primary purpose of the study was to evaluate the adjustment of the eleven children to placement, and to determine whether the degree of pre-placement planning and preparation contributed to the success or failure of each child's adjustment in the foster home. The areas in pre-placement planning and preparation considered were: the factors determining need for placement; preparation of the parent and child for the referral; preparation of the child-placing agency for the referral; selection of the foster home; and preparation of the family and child for placement by the child-placing agency.

The cases were classified in the following manner: four cases of children whose adjustments to placement were successful; four cases of children whose adjustments to placement were only moderately successful; and three cases of children whose adjustments to placement were unsuccessful. Successful adjustment was defined as one in which the child exhibited no serious psychoneurotic or behavior disturbances beyond the first few weeks of placement. Moderately successful adjustment

ment was defined as one in which there was over-all progress in terms of the original reason for referral, but in which there were some extreme psychoneurotic symptoms or behavior disturbances throughout placement. An unsuccessful adjustment was defined as one in which the child ran away or asked for removal from placement, or was removed from placement either by the parents or the agency.

In all four cases where the adjustment of the child to the placement was successful, there was extensive pre-placement planning and preparation. In Case No. 1, where there was the most extensive pre-placement preparation and planning, there was the least evidence of anxiety during the initial phase of placement. In Case No. 2, the child was too young and too ill to prepare, and little preparation needed with the family who did not hold guardianship and would probably never take the child to live with them, but there was extensive inter-agency planning for this placement, and careful selection of foster homes. In Case No. 3 and Case No. 4, there was extensive planning and preparation before placement, and anxiety shown only in the initial phase of placement.

In those cases where adjustment to foster home placement was found to be only moderately successful, there was inadequate preparation in one or more of the areas studied. In two of these cases, there was inadequate preparation of the

ment was defined as one in which there was over-all progress in terms of the original reason for referral, but in which there were some extreme psychoneurotic symptoms or behavior disturbances throughout placement. An unsuccessful adjustment was defined as one in which the child ran away or asked for removal from placement, or was removed from placement either by the parents or the agency.

In all four cases where the adjustment of the child to

the placement was successful, there was extensive pre-placement planning and preparation. In Case No. 1, where there was the most extensive pre-placement preparation and planning, there was the least evidence of anxiety during the initial phase of placement. In Case No. 2, the child was too young and too ill to prepare, and little preparation needed with the family who did not hold guardianship and would probably never take the child to live with them, but there was extensive inter-agency planning for this placement, and careful selection of foster homes. In Case No. 3 and Case No. 4, there was extensive planning and preparation before placement, and anxiety shown only in the initial phase of placement.

In those cases where adjustment to foster home placement

was found to be only moderately successful, there was inadequate preparation in one or more of the areas studied. In two of these cases, there was inadequate preparation of the

parents and child for the referral, and of the agency for the referral, and therefore little opportunity for the child-placing agency adequately to prepare parents and children for the placement. In the third case, there was inadequate preparation of the parents for the placement, since their feelings about placement were not worked through and they had little contact with the child during placement, and the child was seen but not told of placement plans by the child-placing worker. In the fourth case of only moderately successful adjustment, the child was not seen before placement by the child-placing worker, so that there was no opportunity to work through the child's feelings toward separation and placement. In all of these cases, there was evidence of either anxiety or behavior disturbance throughout placement.

In two of the three cases where the adjustment to placement was unsuccessful, there actually was extensive pre-placement planning and preparation made. In the first of the two cases, the child's behavior and medical problems were too severe for a foster home to tolerate, and in the second, despite intensive casework on the part of both the referring worker and the child-placing worker, the parents were unable to work through their feelings about the child's handicap enough to keep the child in placement. The fourth case of unsuccessful adjustment to placement was one in which the adolescent boy did not have the opportunity to participate

parents and child for the referral, and of the agency for the referral, and therefore little opportunity for the child-placing agency adequately to prepare parents and children for the placement. In the third case, there was inadequate preparation of the parents for the placement, since their feelings about placement were not worked through and they had little contact with the child during placement, and the child was seen but not told of placement plans by the child-placing worker. In the fourth case of only moderately successful adjustment, the child was not seen before placement by the child-placing worker, so that there was no opportunity to work through the child's feelings toward separation and placement. In all of these cases, there was evidence of either anxiety or behavior disturbance throughout placement. In two of the three cases where the adjustment to placement was unsuccessful, there actually was extensive pre-placement planning and preparation made. In the first of the two cases, the child's behavior and medical problems were too severe for a foster home to tolerate, and in the second, despite intensive casework on the part of both the referring worker and the child-placing worker, the parents were unable to work through their feelings about the child's handicap enough to keep the child in placement. The fourth case of unsuccessful adjustment to placement was one in which the adolescent boy did not have the opportunity to participate

directly in placement plans and work through his feelings around placement.

Although it is difficult to make valid conclusions from a study of eleven cases, there did seem to be a definite relationship in those studied between the adequacy of pre-placement preparation and planning and the degree of adjustment of the child to the foster home. Where there was the most extensive preparation and planning before placement, there seemed to be the most successful adjustment to it. In those cases of unsuccessful adjustment where there was adequate pre-placement planning and preparation, there seemed to be other factors of either an emotional or medical nature which were too severe to be alleviated.

In conclusion, there seem to be many reactions that the parent and child may have, both to the illness of the child and to medical foster home placement of the child. These reactions must be considered and worked with before and during placement of the physically handicapped child, in order to prevent the experience of placement from being more traumatic to the child than remaining in his own home and for the goal of placement to be met. Much can be done by the referring worker in submitting adequate data to the child-placing agency so that the worker in that agency is better equipped to select a foster home to meet the needs of the child and to work with the parents and child during placement. Much can be done by

directly in placement plans and work through his feelings

around placement.

Although it is difficult to make valid conclusions from

a study of eleven cases, there did seem to be a definite

relationship in those studied between the adequacy of pre-

placement preparation and planning and the degree of adjust-

ment of the child to the foster home. Where there was the

most extensive preparation and planning before placement,

there seemed to be the most successful adjustment to it.

In those cases of unsuccessful adjustment where there was

adequate pre-placement planning and preparation, there seemed

to be other factors of either an emotional or medical nature

which were too severe to be alleviated.

In conclusion, there seem to be many reactions that the

parent and child may have, both to the illness of the child

and to medical foster home placement of the child. These

reactions must be considered and worked with before and during

placement of the physically handicapped child, in order to

prevent the experience of placement from being more traumatic

to the child than remaining in his own home and for the goal

of placement to be met. Much can be done by the referring

worker in submitting adequate data to the child-placing agency

so that the worker in that agency is better equipped to select

a foster home to meet the needs of the child and to work with

the parents and child during placement. Much can be done by

the child-placing worker in helping the child accept realistically the reason for placement and to alleviate some of his fears about separation from his parents and fears of the foster home. The parents, too, can be helped before placement to accept the foster home realistically, by recognizing and working with their feelings around separation and placement of the child. As has been seen from the eleven case presentations, in those instances where there was careful pre-placement planning and preparation, the child did make a better adjustment to foster home placement.

Approved:

Richard K. Conant
Richard K. Conant
Dean

III Role of child-placing worker

- a. Was the parent seen before placement?
 1. Were feelings around placement worked through at all?
 2. Was adequate information on foster home given?
 3. Was need for continued contact between parent and child interpreted to parent?
 4. Did family accept plan for placement?

b. Was child seen before placement?

1. Does child understand why he is being placed?
2. Were child's feelings around separation worked through at all?
3. Was there a pre-placement visit or information on foster home given to the child?

c. Foster Home

1. How and why was foster home selected?
2. How was foster home prepared for the child?

IV What was the Adjustment of the child during placement?

- a. medical standpoint
- b. emotional standpoint

the child-placing worker in helping the child accept
realistically the reason for placement and to alleviate some
of his fears about separation from his parents and fears of
the foster home. The parents, too, can be helped before
placement to accept the foster home realistically, by recog-
nizing and working with their feelings around separation and
placement of the child. As has been seen from the eleven
case presentations, in those instances where there was care-
ful pre-placement planning and preparation, the child did
make a better adjustment to foster home placement.

Approved:

Richard E. Connor
Richard E. Connor
Dean

Appendix I

SCHEDULE

I Reason for the referral

- a. medical situation
- b. home situation
 1. physical factors
 2. emotional factors

II Role of referring worker

- a. How did worker arrive at decision for referral?
- b. Was there a clear explanation to family of reason referral?
- c. Did family understand and accept need for referral?
- d. Was reason for referral made clear to referral agency?
- e. Was adequate medical and social data submitted to referral agency?
- f. Was definition of casework responsibilities made clear in referral process?

III Role of child-placing worker

- a. Was the parent seen before placement?
 1. Were feelings around placement worked through at all?
 2. Was adequate information on foster home given?
 3. Was need for continued contact between parent and child interpreted to parent?
 4. Did family accept plan for placement?
- b. Was child seen before placement?
 1. Does child understand why he is being placed?
 2. Were child's feelings around separation worked through at all?
 3. Was there a pre-placement visit or information on foster home given to the child?
- c. Foster Home
 1. How and why was foster home selected?
 2. How was foster home prepared for the child?

IV What was the Adjustment of the child during placement?

- a. medical standpoint
- b. emotional standpoint

Appendix II

BIBLIOGRAPHYBooks and Periodicals

- Allen, Kathleen, "Caring for Convalescent Children," The Child 10:3, 1945
- Almy, Helen & Catherine Casey, "Public Health Social Work," Commonwealth, Massachusetts Department of Public Health, December 1953
- Baker, Edith & Doris Siegel, Medical Social Services for Children, U.S. Department of Health, Education and Welfare, Children's Bureau, 1953
- Bowlby, John, Maternal Care and Mental Health, WHO, Geneva 1951
- Council on Social Work in Medical Care, United Community Services of Greater Boston, unpublished material on practices and procedures in relation to referrals.
- Crosby, William, "Superintendent's Annual Report, May 1899," The Fiftieth Annual Report of the Children's Mission to the Children of the Destitute.
- Field, Parker B., "Report of the General Secretary," The Sixty-Fifth Annual Report of the Children's Mission to Children.
- _____, "Report of the General Secretary," The Seventy-Sixth Annual Report of Children's Mission to Children.
- Freud, Anna & Dorothy T. Burlingham, War and Children, N. Y. N. Y.: Ernest Willard, 1943
- Freud, Anna, "Role of Bodily Illness in the Mental Life of Children," Psychoanalytical Study of the Child, 7:69, 1953
- Massachusetts Department of Public Health, Facts About Services for Crippled Children, PH-ML-5-3000
- Radinsky, Elizabeth K., "While a Child Stays in a Foster Home," The Child, March 1952

Appendix II

BIBLIOGRAPHY

Books and Periodicals

- Allen, Kathleen, "Caring for Convalescent Children," The Child 10:3, 1945
- Amy, Helen & Catherine Casey, "Public Health Social Work," Commonwealth, Massachusetts Department of Public Health, December 1953
- Baker, Edith & Doris Siegel, Medical Social Services for Children, U.S. Department of Health, Education and Welfare, Children's Bureau, 1953
- Bowlby, John, Maternal Care and Mental Health, WHO, Geneva 1951
- Council on Social Work in Medical Care, United Community Services of Greater Boston, unpublished material on practices and procedures in relation to referrals.
- Crosby, William, "Superintendent's Annual Report, May 1899," The Fifth Annual Report of the Children's Mission to the Children of the Destitute.
- Feld, Parker B., "Report of the General Secretary," The Sixty-Fifth Annual Report of the Children's Mission to Children.
- _____, "Report of the General Secretary," The Seventy-Sixth Annual Report of Children's Mission to Children.
- Freud, Anna & Dorothy F. Burlingham, War and Children, N. Y. N. Y.: Ernest Wilentz, 1943
- Freud, Anna, "Role of Bodily Illness in the Mental Life of Children," Psychosomatic Study of the Child, 7:82, 1953
- Massachusetts Department of Public Health, Notes About Services for Crippled Children, PH-MI-5-3000
- Radinaky, Elizabeth K., "While a Child Stays in a Foster Home," The Child, March 1952

Rafuse, Dr. Janice, "New Hope for the Crippled Child,"
Commonwealth, Massachusetts Department of Public Health,
May 1953

Senn, M.J.E., "Emotional Aspects of Convalescence," The Child
10:24, 1945

Upham, Francis, Dynamic Approach to Illness, N. Y., N. Y.,
Family Service Association of America, 1949

Rafuse, Dr. Janice, "New Hope for the Crippled Child,"
Commonwealth, Massachusetts Department of Public Health,
May 1953

Senn, W.L.E., "Emotional Aspects of Convalescence," The Child
10:24, 1945

Upham, Francis, Dynamic Approach to Illness, N.Y., N.Y.,
Family Service Association of America, 1949

7210-5
2/4

BOSTON UNIVERSITY



1 1719 02481 8298

